

**MENTAL HEALTH OFFICERS AND THE PROBLEMATICS OF  
GENDER**

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### Declaration

This thesis is entirely my own work. This thesis has been composed by myself, and the work has not, in whole or part, been submitted for any other degree or professional qualification.

Signed:



## **ABSTRACT**

This study focusses on the role of the Mental Health Officer and the topic of gender. Twenty Mental Health Officers working for the City of Edinburgh Council Social Work Department were interviewed, ten female and ten male. Meanings of gender are explored in relation to Mental Health Officers' understandings of their professional role and their membership of a social work organisation. Meanings of gender are also explored in relation to their personal views and these are found to overlap with their professional responsibilities.

This thesis uses a qualitative approach informed by feminist theory and methodology. Schutzian phenomenology has been drawn on to explore categorisation and experience. Meanings of gender arise in relation to three areas: personal biography, cultural context, and social institution. Informants' personal biographies emphasise the sense of uniqueness of individuals and raised gender-related topics. These topics are sexuality issues, age, emotions, and the male personal gender. The cultural context of gender, or gender culture, is studied from various informants' views, and shared experiences based on gender groupings are discussed. At the social institutional level, the issue of vertical and horizontal segregation is raised by several informants. Informants also discuss their working relations with medical colleagues, particularly medical doctors.

Key practice issues and policy implications arise from the study. These relate firstly, to reported working practices:

1. substitution of a mental health social worker for one of the other sex
2. joint working
3. avoidance

This study also raises more general issues in relation to mental health social work. Six areas are explored in the thesis: children, heterosexuality, commonality, patriarchy, age, and emotion.

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## **CONTENTS**

<b>CHAPTER 1: INTRODUCTION</b>	<b>4</b>
Overview	4
Background to the Research	5
Key Theoretical Concepts in the Research	6
Relevant Social Work Research	8
 <b>CHAPTER 2: MENTAL HEALTH</b>	 <b>13</b>
Mental Health Officer Role	13
Gender as a Mental Health Issue	19
 <b>CHAPTER 3: MENTAL HEALTH, GENDER DIFFERENCES &amp; WORK ORGANISATION</b>	 <b>21</b>
SECTION 1	
Theoretical Approaches to Mental Health	21
SECTION 2	
Explanations of Gender Differences	27
SECTION 3	
Interactions: Mental Health, Gender Differences & Work Organisation	41
 <b>CHAPTER 4: METHODOLOGY</b>	 <b>52</b>
SECTION 1	
Introduction to Chapter	52
Social Science Research Background	53
The Development of Feminist Research	54
SECTION 2	
The Methodology of This Study	59
Female and Male Informants	60
Experience	62
Reflexivity	66
Black Feminism and Postmodernism	68
Power Differentials	70

SECTION 3	
Data Collection	74
Interviewing	74
Sample	75
Table 1	78
Contextual Elements of the Interviews	81
Schedules	83
SECTION 4	
Data Analysis	91
Summary	96
<b>CHAPTER 5: PERSONAL BIOGRAPHY</b>	98
Individual Personal Biographies	99
Sexuality Issues	103
Age	109
Emotions	114
The Male Personal Gender	123
<b>CHAPTER 6: CULTURAL CONTEXT</b>	
<b><i>THE GENDER CULTURE</i></b>	131
PART 1	
Commonality or Shared Experiences	132
Abuse Issues	144
PART 2	
Categorisations	155
Women	156
Women and Children	156
Women and Relationships	168
Women and Depression	172
Men	177
Men and Aggression	177
Men and a Reluctance to Talk	182
Men and Discrimination	189
Women, Men and Vulnerability	193

<b>CHAPTER 7: SOCIAL INSTITUTION</b>	210
Gendered Segregation in Mental Health Social Work	212
Vertical Segregation	212
Horizontal Segregation – and the Topic of Authority	214
Multi-Disciplinary Working	222
Working with Medical Colleagues	222
Professional Status Differences Between Medical Staff and Mental Health Officers	223
Professional View Differences Between Medical Staff and Mental Health Officers	228
Professional Communication Difficulties Between Medical Staff and Mental Health Officers	237
 <b>CHAPTER 8: PRACTICE ISSUES AND POLICY IMPLICATIONS</b>	 243
Working Practice: Substitution	243
Working Practice: Joint Working	248
Working Practice: Avoidance	249
Six Topics Affecting Practice	250
Contributions of this Study	254
Directions for Future Research	257
 <b>APPENDICES</b>	 259
 <b>LIST OF ABBREVIATIONS</b>	 266
 <b>BIBLIOGRAPHY</b>	 267

# **CHAPTER 1**

## **INTRODUCTION**

### **Overview**

This study is focussed on the role of the Mental Health Officer (MHO) and the topic of gender. The area of inquiry is to explore meanings of gender from the views of Mental Health Officers which relate to their professional role as mental health social workers and to their being part of a social work organisation. Meanings of gender are also explored from the personal views of Mental Health Officers which were found to overlap with their professional responsibilities. This personal area is included because mental health issues are considered to be part of 'life experience', whether directly or indirectly, and are not seen as situated within the professional role only.

The aims are: a) to explore the work of Mental Health Officers as gendered subjects; b) to identify the meanings of gender operating in mental health social work; c) to identify/explore gendered assumptions made by female and male Mental Health Officers; d) to identify/explore gendered practices operating in Mental Health Officers' work; e) to consider the implications for service users of gendered assumptions and practices in mental health social work.

In order to fulfil these aims, I adopted a qualitative research approach informed by feminist theory and methodology. I interviewed twenty Mental Health Officers who were working for the City of Edinburgh Council in different settings including community area offices, hospitals and a health centre. The sample group was deliberately gender-balanced in terms of numbers, and consisted of ten female and ten male Mental Health Officers.

A focal point of the research is the Mental Health Officer role. The main function of the Mental Health Officer is to consider the circumstances of an individual whose case has been drawn to the attention of the Mental Health Officer by health or social work colleagues, or by a private individual, for the purpose of deciding whether there is a need to admit that person to hospital. The MHO will normally make a significant contribution to the view that is reached on whether there is any way by which the health and safety of the individual concerned could be secured other than by hospital admission. In cases where the person is already in hospital the Mental Health Officer can contribute to decision-making concerning continuation of detention. (Social Work Services Group, 1986)

### **Background to the Research**

My interest in this project stems from my work as a Mental Health Officer in the 1990s in central Scotland. At that time, I noticed some differences in the assessments made by colleagues based on, for instance, the gender of service users. Sometimes women appeared to be more quickly conceived of as self-damaging, whereas men were more readily regarded as potentially damaging to others. This discrepancy could result in different recommendations being made concerning services provided to the service users. I was interested in the possible gender differences in the views of Mental Health Officers towards the service users and any implications this might have for social work practice.

I also noticed differences in mental health service provision for women and men. On one occasion I made a referral on behalf of a female service user to a particular community-based resource. Although a placement was available, it was not allocated to this service user on the basis that there were no other female service users attending the resource. I was told by resource workers that a single woman could upset the balance of the all-male user group. Yet, the resource was aimed at both gender groups in terms of its remit.

### **Key Theoretical Concepts in the Research**

A central concern of my study has been that of differences, both within and between the gender groups. In order to explore differences I have drawn from the social work literature and especially the area of mental health social work, and from the feminist literature particularly that of black feminism, as well as the postmodernist literature. Black feminist theory focusses on social differences, such as class and ethnicity, and postmodernist feminist theory involves the notion of power in terms of specific historical and social contexts. These approaches are used to explore meanings of gender difference.

The concepts of mental health and of gender are discussed throughout this dissertation as socially determined. Mental health is now regarded by some as a culturally and socially relative category and its exact boundaries and meanings vary over time and place (Busfield, 1996). Cultures differ, for instance, in the definition of mental disorders. Definitions of mental disorder are seen to change throughout time in any one culture. Also, behaviour which would result in detention in one culture might result in no action at all in another. The social construction of mental disorder takes into account such differences in definition and classification, in relation to cultural and historical contexts.

Gender is understood by some as a set of socially constructed relationships which are produced and reproduced through people's actions, thus highlighting social interaction in the creation and recreation of gender differences (Gerson and Peiss, 2000). The social constructionist perspective of gender also takes account of variation in definitions of masculinity and femininity. It offers an analysis of the plurality of gender definitions, and so of difference (Kimmel, 2000). Differences among women and among men, as well as between women and men, are taken account of in this theoretical perspective.



It is part of my contention that the concept of 'mental health' is created and recreated in the working tasks of the Mental Health Officer which are embodied in the Mental Health (Scotland) Act 1984. The concept of 'gender differences' is involved in that Mental Health Officers are, of course, gendered persons. Also, the Mental Health Officer is part of the 'work organisation' which is a Social Work department.

I have also drawn on Collins' (1991) matrix of domination model. Collins (1991) suggests that oppression operates on the basis of interlocking axes, such as race, class and gender. The conceptual stance towards these axes is *both / and* rather than the western division of *either / or*. Derrida (1978) considered 'difference' from the *both / and* stance. Collins' model adopts this perspective and so any one individual can be seen as *both* privileged *and* penalised in relation to the different systems of oppression, and not simply *either* privileged *or* penalised. A white woman, for example, may be seen as privileged in terms of race but penalised in terms of gender, within this framework of domination or oppression. Using this model has encouraged me to analyse individual accounts of women's and men's experiences from the perspectives of interlocking axes, instead of from any pre-ordered categorisation, such as female means subordination.

I have also made use of Schutzian phenomenology (Holstein and Gubrium, 1994). This is drawn on to understand processes of categorisation which are central to gender, for example, 'female and male', 'women and men', in relation to experience. Schutz noted that an individual approaches the experiential world which every person takes for granted with a stock of knowledge which is social in origin. This stock is composed of constructions and categories known as typifications. They are guidelines for understanding and interpreting experience, and they are always incomplete. Stanley and Wise (1993) argue that fractures can occur between these incomplete categorisations and experiences. For example, a fracture may arise between the category of 'women' and the experiences of women.

My study is interested in the fractures between typifications and experience because they are pathways to explore meanings of gender.

### **Relevant Social Work Research**

I found a gap in the social work research literature, in that the specific area of my project concerning Mental Health Officers and gender difference has not been previously studied. The body of research literature related to this study includes various projects carried out in the area of 'mental health and gender'. Several are specifically concerned with stereotyping. For instance, the classic study carried out by Broverman et al. (1970) found that gender stereotypes are crucial to clinical judgements made by mental health clinicians. They confirmed two hypotheses. Firstly, that clinical judgements concerning the characteristics of healthy individuals will differ depending on the sex of the service user, for instance, healthy women differ from healthy men by being more submissive, less independent, less aggressive, less competitive and less objective. Secondly, that the behaviours and characteristics judged to be healthy for an adult of unknown sex will resemble those judged healthy for men but not for women. Their findings conclude, then, that clinicians hold to a double standard of health, whereby the general standard of health is taken to be male and women are perceived as less healthy than men. These conceptions, then, may be said to be gendered in a stereotypical way.

Other research studies have not found any uniform influence of stereotyping. Phillips (1985) used a procedure and sample similar to those employed by Broverman et al. (1970) to investigate stereotyping in clinicians' judgements of mental health. It was found that traditional feminine traits are seen as more acceptable for adults in general, including men. A more recent study by Loveland (1993) of judgements by mental health professionals and non-professionals, found that the double standard still existed in the general population sample but not in the clinical population sample.

One study of gender differences in mental health work directly involved mental health social workers in England, known as Approved Social Workers (Sheppard, 1991). This studied General Practitioners' (GPs) and social workers' judgements and perspectives in relation to service users, particularly female service users. Sheppard found that the GPs had a clearly differing standard between women and men for commitment to hospital. The GPs referred considerably more women than men for compulsory admission to hospital and with less emphasis on psychotic, that is major, mental illness in the case of the women. However, he also found that the involvement of an Approved Social Worker in the assessment process sometimes resulted in women being diverted away from compulsory admission. This suggests that there may be less defined gender-differentiation in the views of the Approved Social Workers than the GPs on this particular issue. Sheppard does state, however, that Approved Social Workers did seem to take the views of male members of families into account more than those of female members.

These studies have looked at the area of judgements by mental health personnel in relation to the topic of gender. This is of some relevance to my study. However, my project is interested in the professional and personal views of Mental Health Officers, and concerns gender differences both within the gender groups and between them. It builds on previous work but has developed in its own direction through not only my particular interests from my experiences as a Mental Health Officer, but also current developments in social work and feminist theory.

The presentation of findings and analysis has been arranged into four chapters, the first three of which are based on Collins' (1991) matrix of domination model. They are organised in terms of the levels in Collins' model and are as follows: personal biography; cultural context; social institution. The fourth chapter is concerned with practice issues and policy implications arising from these chapters. I will now outline the various chapters as a brief guide to the layout of the thesis.

## Chapter 2. **Mental Health**

The historical background to the MHO role is covered in this chapter, as well as its legislative basis. I present my own experience as a Mental Health Officer. Finally, the issue of gender-differentiation in mental health and mental health services, of which the MHO role is part, is examined.

### Chapter 3. **Mental Health, Gender Differences & Work Organisation**

This chapter presents the theoretical concepts which I draw on during the development of my study. These are principally – ‘mental health’, ‘gender differences’ and also ‘work organisation’. They form the theoretical basis on which the project has been developed.

Different explanations of mental health are reviewed including biological, psychological and sociological explanations. Different explanations of gender differences are reviewed also including biological, psychological and sociological explanations. Feminist and postmodernist explanations of gender differences are also studied. The concept of work organisation is examined, and its significance for practice is discussed.

### Chapter 4. **Methodology**

This chapter draws on feminist-informed methodology, including research literature and feminist theory. It is informed particularly by Collins (1991) matrix of domination, as well as Schutzian phenomenology (Holstein and Gubrium, 1994), and Huberman and Miles (1994) coding and categorisation processes. The different aspects of the methodology are as follows:

- ❑ Studying gender using female and male informants
- ❑ Theorising of experience as a concept
- ❑ Utilising reflexivity as a specific methodological feature in the feminist tradition
- ❑ Drawing on black feminist, and postmodernist, theory
- ❑ Highlighting power differentials relating particularly to gender.

The method of data analysis contains the three processes of Huberman and Miles (1994) – data reduction, data display and conclusion drawing/verification. The data analysis method consists of various ‘stages’ which are not discrete, nor are they followed in a linear mode. The ‘stages’ include: a) tape recordings of interviews b) verbatim transcripts c) diary d) table 1, characteristics of informants e) summaries of topics talked about by each informant f) themes, that is, coding, categorisation and conclusion drawing or verification. The method of analysis is a process of moving between different ways of organising the data and between the data set as a whole and an individual’s experience.

The next three chapters are organised around Collins’ (1991) matrix of domination and follow its three levels: the level of personal biography; the group level of the cultural context; and the social institutional level.

#### Chapter 5. **Personal Biography**

In this chapter, the individual personal biographies of some of the informants are examined. These examples emphasise the sense of uniqueness of each individual. Also, several sections are presented which study gender-related topics in terms of the personal biography of informants. These topics are sexuality issues, age, emotions, and the male personal gender.

#### Chapter 6. **Cultural Context**

In this chapter, the cultural context of gender, or the gender culture, which operates in mental health social work is examined. The chapter is in two parts, each of which deals with issues focussing on different aspects of the gender culture. The first part is concerned with commonality or shared experiences based on gender groupings. Abuse issues in mental health social work are studied as an example of shared experiences.

The second part of the chapter is concerned with categorisations found in the views of some informants and based on the gender groupings, ‘women’ and ‘men’. The

categorisations concerning women are as follows: women and children; women and relationships; women and depression. The categorisations concerning men are as follows: men and aggression; men and a reluctance to talk; men and discrimination. Finally, a categorisation concerning both women and men is studied, that is, women, men and vulnerability.

## **Chapter 7. Social Institution**

This chapter deals with gendered aspects of social work departments as formal organisations. Firstly, the aspect of gender segregation in the form of both vertical and horizontal segregation is examined. The topic of authority in the Mental Health Officer role is related to horizontal segregation. Secondly, the gendered aspects of multi-disciplinary working are studied. The social institutional level of the medical profession as well as that of the social work profession are involved.

Various issues are raised by informants concerning working with medical colleagues, particularly medical doctors. They are presented as follows: professional status differences between medical staff and Mental Health Officers; professional view differences between medical staff and Mental Health Officers; professional communication difficulties between medical staff and Mental Health Officers.

## **Chapter 8. Practice Issues and Policy Implications**

The focus of this chapter is on the practice issues and policy implications which arise from my project. It deals with practices, such as, substitution, joint working, and avoidance. Also, six topics affecting mental health social work are presented as follows: children; heterosexuality; commonality; patriarchy; age; and emotion. These stem from the previous findings and analysis chapters. The contributions of my study to the legislative and policy background of mental health social work, and to the feminist social work literature, are presented. Finally, a section on 'directions for future research' concludes the chapter.

## **CHAPTER 2**

### **MENTAL HEALTH**

This chapter examines, firstly, the role of the Mental Health Officer and, secondly, gender as a mental health issue.

#### **Mental Health Officer Role**

Prior to the nineteenth century the treatment of the insane held within private madhouses, workhouses and prisons had involved physical coercion, fear and force. However, in the first half of the nineteenth century, the asylum became established as a remedial institution where the sanity of sick human beings might be restored by care. This ideological shift has been called the first psychiatric revolution (Showalter, 1987).

It was the Reform Movement which exposed abuses in the existing madhouses and asked how the asylum model could be modified to overcome such defects. (Scull, 1985). Based on the assumption that asylums should continue to treat lunatics, the reformers' goal was the compulsory public provision and inspection of a nationwide asylum system. In 1845 the reformers' aims became law and the Reform Movement resulted in the setting up of publicly financed and regulated asylums (Ingleby, 1985).

In Scotland, the General Board of Commissioners in Lunacy was operational from 1859 until 1913. This Board was charged with responsibility for supervising the care and treatment of persons suffering from mental disorder. It was followed by the General Board of Control until 1960 when the Mental Welfare Commission was



brought into being by the Mental Health (Scotland) Act 1960. The Commission continues to discharge its responsibilities to date. The 1960 Act repealed the Lunacy (Scotland) Acts, 1857 to 1913, and the Mental Deficiency (Scotland) Acts, 1913 and 1940.

Asylums were reconceptualised as hospitals in the nineteenth and into the twentieth century (Dingwall et al., 1988). The medical profession established their dominance in this domain in various ways. The concept of 'mental illness', for instance, was broadened and new functions of control and surveillance applied to the non-hospitalised population. New therapies and professional alliances began to develop, such as with psychology (Ingleby, 1985).

The role of the Mental Health Officer was developed in relation to the medicalisation of mental illness and to the establishing of psychiatric hospitals and units. Despite the concept of 'community care' being advanced during the 1950s with the work of the 1957 Royal Commission (DHSS Royal Commission on the Law relating to Mental Illness and Mental Deficiency), the hospital remained the main facility for the treatment of mental illness away from the patient's own home (Social Work Services Group, 1986).

The Mental Health (Scotland) Act 1960 was based on the view that people should be treated in hospital only when it was deemed necessary, and that this treatment should be on the same basis as patients suffering from other illnesses. For the small group of patients for whom detention in hospital was necessary, it was considered that such detention should be based on the widest range of professional expertise and take account of any alternative methods of care and treatment thought to be both appropriate and available. This arose as a broad policy objective in the post-war years due to the eagerness of health service planners to open up access to such treatment on a more general basis (Social Work Services Group, 1986).



The Mental Health (Scotland) Act 1984 tightened up procedures for protecting the rights of the individual by focusing on whether it is right for the care and treatment of an individual to be undertaken in a psychiatric hospital under conditions of detention. Under the terms of the Act, a person should not be detained without the local authority being notified, except in an emergency procedure. The aim of joint consideration of the patient's circumstances and needs from both the social and medical perspectives was that this would lead to more comprehensive approaches to the treatment and management of mental illness in Scotland (Social Work Services Group, 1986).

The Mental Health (Scotland) Act 1960 required local authorities to appoint Mental Health Officers. However, their role was of less consequence than that enacted in the Mental Health (Scotland) Act 1984. The 1984 Act introduced the requirement for local authorities to appoint qualified and experienced personnel to be involved in the compulsory detention of people with mental disorders. This legislation gave Mental Health Officers a formal place in these proceedings in association with medical colleagues. For instance, Section 19 (5) of the 1984 Act states in relation to a hospital admission application that the Mental Health Officer shall:

...interview the patient within the period of 14 days ending with the date on which the proposed application is submitted to the sheriff for his approval and satisfy himself that detention in a hospital is, in all the circumstances of the case, the most appropriate way of providing the care and medical treatment which the patient needs... (Mental Health (Scotland) Act, 1984, p. 15)

In the Mental Health (Scotland) Act 1984, the term 'mental disorder' is defined as 'mental illness or mental handicap however caused or manifested' (Section 1[2]).

The primary function of the Mental Health Officer is to assess whether compulsory detention is necessary in individual cases and to assess whether alternatives to detention may be appropriate and feasible. The Mental Health Officer has to be satisfied that detention in a hospital is in all circumstances of the case the most

appropriate way of providing the care and medical treatment the patient needs. In the course of their assessment, Mental Health Officers draw on a wide range of evidence. This evidence includes reference to medical and social work records and interviews with the individual (The Scottish Office, 1994).

*The Mental Health Officer's Assessment:*

The Report of the Social Work Services Group Working Party (1983) stated: 'The Mental Health Officer's ...assessment of the circumstances in an individual case should lead him to one of the following conclusions:

- i. that there is no alternative to medical treatment and care in hospital as a formal patient
- ii. that there is no alternative to medical treatment and care in hospital but that the patient wishes to receive such treatment in care informally
- iii. that there is another possible course through which treatment and care may be organised and provided in the community with or without recourse to compulsory measures (e.g. guardianship..) subject to negotiation with the responsible medical officer
- iv. that there is a firm social care alternative to treatment in hospital
- v. that the relatives wish to assume full responsibility for the care of the patient with the support of the health and social work services as appropriate'

Section 26 of the Mental Health (Scotland) Act 1984 holds the principal requirement of MHOs to provide reports on the Social Circumstances of patients. This concerns those who have been admitted to hospital under the emergency procedure (Section 24) and who are being detained further under the short-term provision. The purpose is to allow the patient's mental state and needs to be fully assessed. (Social Work Services Group, 1986). These reports are provided to the Responsible Medical Officer and the Mental Welfare Commission.

In making the assessment of the Social Circumstances of a patient, the Mental Health Officer as a social worker is also alert to any evidence of the patient's need

for other social input, such as support to family members. An exchange of views normally occurs between the Mental Health Officer and the appropriate member of the clinical team about any proposed action. The hospital-based social work staff are usually kept fully informed (Social Work Services Group, 1986).

The Scottish Executive published statistics of staff of Scottish Local Authority Social Work Departments who worked with people with mental health problems in 1999 – it was 1% (Stats Bulletin, 2001). A study of MHO work in Scotland (Smith, 1991) carried out between 1989 and 1990, and conducted in all Regional and Island authorities, recorded a total number of 538 Mental Health Officers in post at the beginning of monitoring. This study found that MHOs were based in three main sites: adult psychiatry hospitals, community-based teams, and out-of-hours or emergency duty teams. MHO work consisting of assessment under various sections of the Mental Health (Scotland) Act 1984, was in order of volume: Section 26 (detention up to 28 days); Section 24 (detention up to 72 hours); the preparation of social circumstance reports and Section 18 (detention for a period of up to six months). Assessment under Guardianship, unspecified referral work, work following Criminal Procedure and review of detention also featured in the MHO workload. Mental Health Officers were predominantly engaged in work which resulted in the use of compulsory powers of care.

The statutory work of Mental Health Officers concerns adult service users. The mental health problems of children are the concern of agencies, such as, the children's mental health services network and the Children's Panel. A study of children and young people referred to the Children's Hearings system in February 1995 found that a number had recorded psychological or psychiatric difficulties (Waterhouse et al., 1999).

The legislative background which is of relevance to Mental Health Officers includes the following: Mental Health (Scotland) Act 1960; Mental Health (Scotland) Act 1984; Mental Health (Patients in the Community) Act 1995 (c.52); Criminal

Procedure (Scotland) Act 1995; Mental Health (Amendment) (Scotland) Act 1999; Mental Health (Public Safety and Appeals) (Scotland) Act 1999; Adults with Incapacity (Scotland) Act 2000. The Acts of 1999 and of 2000 have been enacted since I carried out the interviews with the sample Mental Health Officer population for this study.

A review of mental health legislation in Scotland has recently been undertaken by the Scottish Executive and draft proposals for reform were put forward in June 2002 as the Draft Mental Health (Scotland) Bill. In this Draft Bill, the terms of the appointment of Mental Health Officers are listed in Part 3 entitled "Local Authority and Health Board Duties". Also in this Draft Bill, the duties of Mental Health Officers are listed in Part 4 entitled "Compulsory Treatment". Other Parts of this Draft Bill refer to, for instance, "The Mental Welfare Commission for Scotland", "The Mental Health Tribunal for Scotland", "Mentally Disordered Persons: Criminal Proceedings", "Medical Treatment" and "Patient Representation".

### Personal Experience

I have been an accredited Mental Health Officer since 1992. At that time, I worked for Lothian Regional Council based at the Livingston Area Office. I worked on the mental health duty rota there, and also when I moved to Bathgate Area Office. In both locations, I worked with mental health service users in an emergency capacity, as well as in a longer-term planning and supportive capacity. I also have experience of working with service users in a hospital setting. In 2000, I was based at Stirling Royal Infirmary as part of the Adult Mental Health Team. In each location I was consulted by other social work staff when my training and experience as a Mental Health Officer could be helpful. I also participated in the training of other social workers on the MHO role in Livingston Area Office.

Other work which I have carried out based on my experience as a Mental Health Officer has included compiling Social Circumstance Reports, from an independent

viewpoint, for the purposes of solicitors appointed as Curator Ad Litem to the Courts. The primary purpose of these reports was a recommendation towards or against the pursuit of Guardianship in individual cases.

### **Gender as a Mental Health Issue**

Gender-differentiation as an issue in mental health and mental health services is not a recent phenomenon. Chesler (1996) notes that as early as the sixteenth century women were 'shut up' in madhouses by their husbands. By the seventeenth century special wards were reserved for prostitutes, pregnant women, poor women, and young girls in France's first asylum, the Salpêtrière. By the end of the nineteenth and throughout the twentieth century, Chesler (1996) argues, the portraits of madness utilised by both psychiatrists and novelists were primarily of women.

Showalter (1987) states that in England in the nineteenth century, women were believed to be more vulnerable to insanity than men, to experience it in specifically feminine ways, and to be differently affected by it in the conduct of their lives. She argues that madness, in an obvious sense, is a female malady because it is experienced by more women than men. By the middle of the nineteenth century, records showed that women had become the majority of patients in public lunatic asylums. In the twentieth century, women have made up the majority of clients for psychiatric hospitals, outpatient mental health services and psychotherapy (Showalter, 1987).

In 2000 the Scottish Executive published a review of literature relating to mental health legislation, in reference to the proposed reform of the Mental Health (Scotland) Act 1984. Gender-differentiation is to be found in some of the issues concerning mental health and mental health services.

It reported that detention under all sections of the Act continues to rise steadily, and that detention increases for women with age. Also, there has been a dramatic rise in

first psychiatric admissions for young men with a diagnosis of paranoid states, non-organic psychosis and, to a lesser extent, affective disorders. This rise may be linked to a greater incidence of substance abuse (Scottish Executive, 2000).

The review reported a number of concerns regarding the provision of secure accommodation across Scotland, such as facilities for women sometimes being inadequate, particularly where hospitals are contracting. Most patients admitted to intensive psychiatric care units are male with a diagnosis of schizophrenia and a history of physical violence to others. Also, the number of suicides reported to the Mental Welfare Commission continues to increase. This increase is made up mostly of men. The number of women remains constant.

Gender issues remain relevant today as well as historically. Mental Health Officers are part of the mental health services in Scotland and gender-differentiation in relation to their views and experiences is the specific interest of my study.

## **CHAPTER 3**

### **MENTAL HEALTH, GENDER DIFFERENCES & WORK ORGANISATION**

This chapter is divided into three sections as follows: ‘theoretical approaches to mental health’; ‘explanations of gender differences’; ‘interactions: mental health, gender differences and work organisation’.

The sections outline the different perspectives in each of these three areas in this large field. The final section includes my own approach to this complex subject, focussing on how the concepts relate to one another within my study.

***The terms used in my study*** are ‘mental health’, ‘mental distress’ and ‘mental disorder’. ‘Mental health’ is taken as a broad term concerned with mental functioning. ‘Mental distress’ is a generic term referring to distress within mental functioning, and ‘mental disorder’ requires diagnostic categorisation, such as schizophrenia, affective disorders and anxiety disorders.

#### **SECTION 1**

##### **Theoretical Approaches To Mental Health**

Three theoretical approaches to mental health are offered, namely biological, psychological and sociological.



### Biological Explanations

Biological perspectives refer broadly to approaches which relate abnormal behaviour to biological processes (Rathus & Nevid, 1991). These view psychological problems as resulting mostly from physical causes.

Although ancient societies attributed abnormal behaviour to divine or supernatural forces and although medieval people believed in possession by evil spirits, the basis of the medical model stems from Hippocrates' (ca.460-377BC) view that abnormal behaviour could result from biological imbalances. A further step towards a biological explanation for mental health came from Wilhelm Griesinger, in the nineteenth century, and Emil Kraepelin, who were both influential in the development of the modern medical model which likens abnormal behaviour patterns to physical illnesses. Medical frameworks, or what is often termed the 'medical model', consider mental health problems to be like a form of physical illness. This perspective assumes that mental illnesses can be identified and classified, and so diagnosed in terms of syndromes and symptoms (Heller et al., 1996).

Dingwall et al. (1988) note that from the beginning of the nineteenth century, medicine slowly began to become an occupation based on a scientific model of research, incorporating classification of diseases. Kraepelin's categorisation of mental disorders laid the base for the development of modern systems of classification (Rathus & Nevid, 1991). These modern systems include the *International Statistical Classification of Diseases* (ICD) produced by the World Health Organisation, and the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM).

The DSM system is based on a medical approach to classification whereby problem behaviours are viewed, as stated earlier, as symptoms of underlying syndromes or disorders. According to Rathus and Nevid (1991), this approach has been criticised as focussing too much on what may happen within the



individual and not enough on external influences on behaviour, such as societal pressures.

Banton et al. (1985) similarly criticise the medical model for regarding the illness as residing inside the individual, and thereby calling into question all of that person's behaviour and also their rationality.

Goldberg and Huxley's model (1992), on the other hand, is termed a 'bio-social model' which bases itself on both biological and social factors in attempting to understand common mental disorder. Goldberg and Huxley propose this model to bring common mental disorders into a unifying framework, and take into account advancing knowledge in biological psychiatry. Such disorders are encountered in community settings and involve a breakdown in normal functioning. Goldberg and Huxley suspect that there is a single genetic vulnerability factor in relation to common mental disorders and that differing syndromes of minor disorder are determined partly by factors learned within the family and partly by differing environmental factors occurring later in life.

Goldberg and Huxley (1992) also suggest that instead of the myriad subdivisions of minor illness to be found in classificatory schemes, such as the *International Statistical Classification of Diseases*, there are only a very limited number of ways that humans respond to psychological stress. These ways are defined by two underlying dimensions of symptomatology: anxious symptoms and depressive symptoms. Combinations of these sets are more common than either on its own. The apparent diversity of common illnesses is because there are a number of ways of responding to the experience of symptoms of anxiety or depression, according to Goldberg and Huxley (1992), and these various ways are associated with clusters of symptoms which are categorised in the official classification schemes.

Although Goldberg and Huxley (1992) allow for a multiplicity of symptoms, their model seems to be reductionist through its limiting human response to stress to only two underlying dimensions, those of anxiety and of depression. Such reductionism appears to diminish the complexities of human experience.

### Psychological Explanations

Freud's contribution to psychological explanations of mental health is an important one. Freud believed that the mind is composed of three regions - the conscious, the preconscious, and the unconscious. He also theorised that three mental or psychic structures exist - the id, the ego, and the superego. The id represents basic biological drives, the ego stands for reason, and the superego represents moral values. Abnormal behaviour patterns are theorised as occurring because of imbalances among these psychic structures (Rathus and Nevid, 1991).

Psychodynamic perspectives, of which Freud's approach is one, have had a profound impact on Western culture and understanding of human behaviour. Psychodynamic theories hold certain tenets in common, such as unconscious motivation and the importance of childhood experiences in shaping personality and behaviour. However, it is argued that many of the propositions of psychodynamic perspectives remain speculative and may not be testable by scientific means (Rathus and Nevid, 1991).

Another 'school' of psychology which continues to be influential today is behaviourism based on the principles of learning. Lindzey et al. (1978) state that behaviourists are willing to analyse behaviour into fundamental elements but that they dismiss the notion that consciousness could be studied objectively. Instead, they are interested in the objective observation of overt behaviour. The behavioural approach regards abnormal behaviour as having been learned in the same way that normal behaviour is learned.

Learning models, however, according to Rathus and Nevid (1991), have been criticised for paying inadequate attention to genetic factors in explaining behaviour and also for failing to account for the richness of human experience.

Cognitive perspectives form another branch of psychological explanation. These focus on the roles of thinking and information-processing in explaining human

behaviour (Rathus and Nevid, 1991). Cognitive theorists are interested in how maladaptive thoughts or cognitions may lead to emotional problems. It is questionable, though, whether distorted cognitions cause emotional problems like depression or merely result from these problems.

Modern psychology today tends to be eclectic to some degree, drawing from various theories according to the needs of a particular situation.

There are, then, various theoretical approaches to the study of human behaviour, both normal and abnormal, within the field of psychology. These result in different views of what constitutes mental health and abnormal behaviour. These approaches tend to focus on the individual and do not usually include the cultural or social context of mental health, which appears to be a weakness of such theorising.

### Sociological Explanations

Sociological explanations of mental health look to society and the social context rather than biology or individual psychology in order to explain differences.

Labelling theory is a key sociological explanation of mental illness. Labelling theorists, according to Banton et al. (1985), have argued that in 'mental illness' some act is arbitrarily defined by social convention as deviant. The perpetrator of that act is then labelled and defined as an outsider and in turn treats her/himself as such. This person internalises the labels used by others and acts in accordance with them. Labelling theory thus describes how 'mental illness' is constructed as a set of meanings within specific social environments, and is not some isolated entity. The defects of such theory include that it implies individuals are relatively powerless when faced with social labels, and it assumes that the operation of social messages is univocal and clear. Also, the complications involved in coping with psychological distress are neglected (Banton et al., 1985). It has been argued, moreover, that there is an inadequate

analysis of power in labelling theory and that there is no way of understanding the processes by which labels are attached to particular behaviours (Cree, 2000).

Another approach adopted by psychiatry is to use a categorical model in which specific mental disorders constitute the building blocks that construct the generic term (Busfield, 1996). The disorders involve, or are thought to involve, some disturbance of mental functioning. However, the boundaries between mental disorder and physical illness, as well as social deviance, are contested areas, according to Busfield (1996). A particular condition may be deemed a physical illness or a mental disorder according to the situational context. For instance, anorexia may be considered as a physical illness or a mental disorder depending upon the situation. Also, certain behaviour may be viewed as socially deviant or as stemming from mental disorder. It is this type of choice which makes definition of mental disorder problematic.

Busfield (1996) states that mental disorder is a culturally and socially relative category, and its precise boundaries and meanings vary over time and place. It is, then, she argues, socially constructed. Busfield (1996) theorises mental disorder in terms of the regulation of reason and rationality, and states that the social characteristics of those who are identified as mentally disturbed need to be taken into account, including the dimension of gender. She bases this theory on Foucault's (1967) identification of madness as unreason (Busfield, 1996).

Acharyya (1996) states that although categories of classification are taken to be culture-free, differences across cultures exist. For example, a psychiatrist may be unsure how to classify, or whether to classify, the distress of someone from another culture with an attitude to well being or illness which is quite different to her/his own. Classification of mental disorder is regarded by Busfield (1996) and Acharyya (1996) as problematic. The reasons for classification being problematic include contested boundaries of mental disorder, for instance, with social deviance (Busfield), and also differences across cultures (Acharyya). There is variation in classification of mental disorder according to both of these authors. These arguments strengthen the perspective of mental disorder as

socially constructed because social constructionism takes account of variation and does not consider mental disorder to be defined in any fixed sense.

The social constructionist view of mental disorder, then, theorises difference rather than viewing mental disorder as a static concept. Social constructionism takes into account differences in definition and classification, which relate to cultural and historical contexts, for instance, cross-cultural differences.

## **SECTION 2**

### **Explanations Of Gender Differences**

The literature on gender differences has a long history dating back to at least the eighteenth century and Rousseau's writings dedicating women to their husbands and to maternity. More recently, in anthropological research in the 1930s, Margaret Mead studied the area of gender differences in her book '*Sex and Temperament in Three Primitive Societies*' (1935). The Women's Movement in the 1970s moved the whole discussion on by challenging much of the previous writing and research in its attempts to explain differences between the two genders in their behaviour and attributes.

Three main explanations of gender differences are offered, namely biological, psychological and sociological. These types of theoretical approaches have been drawn on in the previous section concerning mental health. Feminist explanations and postmodernist explanations also enter the discussion on gender differences. Although each of these theoretical approaches informs the subject area of gender differences, my study is based on the sociological approach and draws on the feminist and postmodernist explanations. There are overlaps among the several approaches.

### Biological explanations

An important biological explanation is the theory of sociobiology which was developed in the 1970s (Kimmel, 2000). Barash (1982) defined sociobiology as the application of evolutionary theory in order to explain the social behaviour of animals including human beings (Hyde, 1991).

Sociobiology is part of the biological determinist tradition of thought, and as such it attempts to explain the origins of gender-differentiated roles and positions held by women and men in terms of biology (Kramarae and Treichler, 1992).

A key concept in sociobiology is derived from the evolutionary theory of natural selection, namely that social behaviours are adaptive in terms of survival (Hyde, 1991). For example, it is argued that women do most childcare because the female has a greater parental investment and so it is adaptive for her to continue to care for her offspring. Also, in terms of having children, maternity is certain whereas paternity is not. Therefore, it is further argued that this link increases a woman's fitness to care for the offspring and to make sure that they, and her genes, survive. This is said to explain why women carry out the majority of childcare (Hyde, 1991).

The theory of sociobiology considers that differences in personalities and cultures derive from biological development which is influenced by evolutionary selection. It is theorised that 'natural' differences which occur are the basis of social and political arrangements (Kimmel, 2000). It is argued, then, that biology underpins personality and culture, and that social and political organisation follows on from the differences which arise. This theory, then, gives biology a position of prime importance to explain social and political developments.

There are various arguments against sociobiological explanations for gender differences. According to Kimmel (2000), behaviour differs between cultures and similar behaviours may have different meanings in varied contexts. He argues that 'innate gender differences' do not therefore automatically produce the social, political and economic inequalities of contemporary society. For instance, men do not automatically become societal leaders because of innate aggression.

Sociobiology is also criticised for extrapolating beyond what might reasonably be concluded from the data and into areas which cannot be empirically tested. For instance, natural selection cannot be tested in relation to characteristics, according to Kimmel (2000). Also, some feminist psychologists have objected that biological explanations usually rationalise the perpetuation of the status quo (Hyde, 1991). Sociobiologists, as Hyde (1991) states, do a highly selective reading of both data and theories, for instance, viewing data from an androcentric, or male-orientated, perspective. Further, it has been argued that sociobiology itself rests on an outmoded version of evolutionary theory that is now considered naïve (Hyde, 1991).

A distinction has been made in feminist theory between 'sex' and 'gender', by basing 'sex' on 'biology' and 'gender' on 'attributes'. Busfield maintains that the former denotes:

...bodily differences between men and women in the reproductive organs... (1996, p. 32).

The latter denotes:

...differences in male and female qualities and behaviour which were held to be a product of social factors and could not be reduced to matters of biology. (1996, p. 32).

According to Humm (1989), feminist theory in the 1980s was careful to distinguish between sex and gender, taking the view that sex is biological and that gender behaviour is a social construction. However, a growing emphasis on



gender differences as socially constructed and varying across time and place began to dominate (Busfield, 1996). Consequently, the biological argument began to diminish within feminist theory.

Hudson (1989), for instance, argues that women and men are socially rather than biologically determined and consequently able to be changed by the conscious intervention of other human beings. This, then, is a view opposed to the biological determinist tradition of which sociobiology is part.

In terms of feminist theory, then, biological argument generally lost place to social constructionist argument, in explaining gender differences.

In my view, biological explanation seems to reduce the complexity of human experience to one dimension which is regarded as the basis of all else. This reductionism appears to diminish the richness of this area of inquiry. Also, diversity is problematic for biological arguments, that is, differences within social groups, such as the social group 'women' and the social group 'men'. Biological theorising tends to study differences between women and men to explain behaviour and tends not to focus on differences among women and among men.

### Psychological explanations

Psychological explanations of gender differences have been highly influential in setting the parameters for discussion of gender over the last thirty years. Four theories are: Freudian theory of gender differences; social learning theory; cognitive developmental theory; gender schema theory. Each of these has made a contribution to the theorising of gender. However, they have also been critiqued. I will look at each of these explanations in turn, in terms of the theory itself and also criticisms of it.

Firstly, Freudian theory of gender differences, according to Kimmel (2000), has had a lasting influence on studies about the relationship between gender identity and sexual behaviour and sexual orientation. Freud believed that the anatomical



differences between females and males lead toward different personalities. However, he did not believe that such differences could be explained in biological terms alone, but thought that different experiences from infancy onward were pertinent to their development, particularly within the family.

There is a biological basis to Freud's theorising of gender differences. The biological basis of such theory tends to leave it open to criticisms levelled at biological explanations earlier. Those are the problems of reducing the complexity of human experience to one dimension and of explaining diversity.

Secondly, social learning theory is a major theoretical system in psychology designed to describe the process involved in human development, and it has been used to explain the development of gender differences (Hyde, 1991). The theory uses the notion of direct reinforcement to explain the shaping of children's behaviour, that is, rewards and punishments are given differentially to boys and girls for gender-typed behaviours. Consequently, children come to perform the rewarded gender-appropriate behaviours more frequently and the punished gender-inappropriate behaviours less frequently (Hyde, 1991).

It seems that adults may differentially reinforce some gender-typed behaviours, for example, praising boys for showing leadership qualities. However, Hyde (1991) argues that there are probably other processes apart from direct reinforcement also involved in the development of gender differences. One other process may be the element of choice, for instance, children can choose to perform or not to perform behaviours against adult reinforcement.

Thirdly, Kohlberg (1966) extended Piaget and Inhelder's cognitive developmental theory to the realm of gender roles. The latter theorists discovered that the cognitive organisations of children change systematically over time, and they constructed a theory of cognitive development to describe the progression of these changes. The child's concepts of gender and gender identity undergo developmental changes parallel to the development of other concepts. The child learns a set of rules regarding what females do and what males do and behaves accordingly – gender role learning.

Kohlberg (1966) suggests that one of the child's main motives for adopting a gender role is the power and value the child sees in that role. There is a problem, however, for the theory in terms of female gender-role development, according to Hyde (1991), in that the female role has less power and value, and so there is less motivation for it to be adopted.

Finally, another psychological theory of gender differences is that of gender schema theory (Hyde, 1991). A schema is a concept from cognitive psychology. It is a general knowledge framework that a person has about a particular topic and it organises and guides perception. Bem (1981) applied schema theory to understanding the gender-typing process and consequently she proposed that each of us has as part of our knowledge structure a gender schema, a set of gender-linked associations (Hyde, 1991). The gender schema represents a basic predisposition to process information on the basis of gender, for example, to dichotomise things on the basis of 'female' and 'male'.

This theory has contributed to explanations of gender differences in terms of processes of association and dichotomy. To process gender as a dichotomy does not lend itself so readily to theorising differences within the gender groups as it does between them. In other words, it more readily explains differences between women and men than it does among women and also among men.

These psychological explanations, as previously stated, have contributed to the theorising of gender and have also been critiqued. Psychological theorising tends to focus on individuals rather than society. In my view, this limits the influence of psychological explanations since the analysis of social relations seems to be central to understanding the concept of gender. In other words, psychological explanations of gender differences tend to miss the social context and social interactions. Also, such explanations tend to theorise gender difference in terms of a female/male distinction, and to categorise the groups 'women' and 'men' separately. They are often helpful, then, in understanding differences between the genders but are not of direct relevance toward understanding gender differences in terms of variation, for example, within the

gender groups. Theories which explain differences within, as well as between, the gender groups are needed in my study, as both aspects are of interest.

### *Sociological Explanations*

Sociological explanations of gender differences rest on the premise that in order to explain differences, we need to look at society and social meanings rather than at biology or individual psychology. There are a number of classical and more recent approaches to this sociological theorising of gender differences.

One such classical theory is that of sex role theory, which argues that society has two types of major function – reproduction and production, and that these are two types of roles to be fulfilled by two different types of people, female and male respectively (Kimmel, 2000). However, there are various criticisms of sex role theory, such as the differences among women and also among men which do not lend support to a single female sex role or a single male sex role. There are differences among women, for instance, relating to class, ethnicity, and sexuality, which can lead to variation in terms of the roles that women adopt. For example, whether a woman has children or not can be one of the defining features of the roles that she adopts.

The related area of gender stereotyping involves sets of beliefs about the characteristics of all members of a particular group, that is, women or men. These sets of beliefs include information about physical appearance, attitudes and interests, psychological traits, social relations and occupations. As stated earlier, Broverman et al. (1970) found from a research study carried out in an American hospital that mental health clinicians tend to have different concepts of health for women and for men, and that these differences parallel the sex-role stereotypes prevalent in western society. For instance, clinicians are more likely to suggest that healthy women differ from healthy men by being more submissive, more easily influenced, more conceited about their appearance, less aggressive, less objective and more emotional. Broverman et al. (1970) state that this seems to be an unusual way of describing a healthy individual. They

are casting doubt on whether the given description indicates a healthy person at all.

Other research has shown that whereas females are stereotypically thought of as relational, that is, concerned with social interaction and emotions, males are stereotypically considered to be instrumental or 'agentive' (Golombok and Fivush, 1994). This type of theorising may not adequately account for variation particularly within social groups, since it is constructed in terms of one gender as opposed to the other.

More recent theorising includes the social constructionist perspective on gender relations. This theorising of gender differences incorporates the historical and cultural contexts which are involved in constructing them. That is, social constructionist theory in explaining gender differences pays attention to factors, such as time and location. Kimmel (2000) states that this takes account of the variation in definitions of masculinity and femininity between cultures; and across time; in any one culture at any given time; and over the course of a person's life. Therefore, a strength of social constructionism is that it offers an analysis of the plurality of gender definitions, and so of difference -- within the gender groups as well as between the gender groups.

From this perspective, gendered identities are created within the contexts of our interactions with others and within the institutions we inhabit (Kimmel, 2000). That is, gender is something we do, rather than something we have.

Similarly, Gerson and Peiss (2000) argue that gender is a set of socially constructed relationships which are produced and reproduced through people's actions. They state that this view highlights social interaction rather than more unidirectional processes of socialisation and/or oppression. Viewing social relations in terms of patriarchal hierarchy, for instance, could be considered as focussing on unidirectional processes of gender oppression -- that is, female as inferior and male as superior. A strength of regarding gender instead in terms of socially constructed relationships is that this incorporates multi-directional processes. Gender, then, is defined by socially constructed relationships

between women and men, among women, and among men in social groups. According to Kimmel (2000), power is regarded not as the consequence of gender difference, but rather that it produces those gender differences in the first place.

Social constructionism is usually contrasted with essentialism. De Lauretis (1994) argues that essentialism defines woman's identity or attributes independently of her external situation. De Lauretis rejects essentialism in theorising gender. She argues that gender is not an innate feature, as sex may be, but a sociocultural construction. Women experience living in the world as female in different sociocultural contexts and this is what makes them women and not men (De Lauretis, 1994).

In relation to the gender of men, Hearn and Morgan (1990) point out that it has been argued that 'men' and 'masculinity' are socially constructed entities, and that the experience of being a man and of masculinity are not uniform. Hence, Hearn and Morgan state that the terminology should be pluralised to 'masculinities' and that the differences need to be theorised.

The strength of social constructionist theorising of gender differences seems to be that it can account for differences within as well as between the social groups of 'women' and 'men'. Also, social and historical contexts are taken into account through regarding gender differences as socially constructed in historically located interaction.

### *Feminist Explanations*

Current feminist explanations of gender differences have developed from an original emphasis on oppression. Socialist feminism and radical feminism have been the major Western feminist theories. Both are concerned with a political analysis of the position of women in society. Socialist feminism is concerned with a class perspective and radical feminism with patriarchal hierarchy.

Socialist feminism argues that:

women are second-class citizens in patriarchal capitalism which depends for its survival on the exploitation of working people, and on the special exploitation of women (Humm 1989, p.213).

This feminism theorises in terms of gender and class. It argues that men have a particular material interest in the domination of women and that various institutional arrangements are constructed by men in order to perpetuate this domination. The roots of women's oppression, then, lie in the economic system of capitalism, according to socialist feminism. Radical feminism is critical of socialist feminism, according to Humm (1989), for not including the centrality of the institution of heterosexuality to the oppression of women.

Radical feminism argues that women's oppression stems from the categorisation of 'women' as an inferior class to that of 'men', on the basis of gender (Humm, 1989). It considers patriarchy, or male supremacy, to be the defining characteristic of society (Daly, 1999). The focus of this feminism is on male domination, and it claims that all forms of oppression are extensions of male supremacy. This view has been critiqued by socialist feminism for not including the centrality of class.

Currently, however in my view, black feminist thought and postmodernist feminist thought, are principally setting the terms of theoretical debate. (Postmodernist feminist thought will be examined in the next section 'Postmodernist Explanations')

Black feminist thought is concerned with understanding the various aspects of oppression, such as race, gender, class and sexuality (Humm, 1989). It emphasises the interaction of the different types of domination, such as ethnicity and sexual orientation. Black feminist theorising often analyses oppression in terms of domination (Hooks, 1989). It is interested in differences and how these relate to the theorising of oppression. Black feminist theory studies the boundaries of sisterhood between black and white feminists in order to understand the contradictions inherent to gender, race and class within the context of a racist society (Humm, 1989). Some black feminists argue that all



feminist theory must understand imperialism and challenge it. They argue for a resistance to any form of imperialism, for instance, a dominating interest in gender issues by some white feminists.

Orme (2001) points out that it was black women who first critiqued feminist thought because even when it theorised gender as a construction of social relations and recognised the difference which gender makes, feminism ignored other dimensions of social identity as well as the diversity of women's experience.

A principal source which I draw on in my project is that of Collins' (1991) multiple axes model of domination, which has arisen from the context of black feminist thought. As stated earlier, this regards axes of oppression as interlocking and is based on the conceptual stance of *both/and* rather than the western division of *either/or*. Consequently, any person can be seen as *both* privileged *and* penalised, for instance, in relation to race, gender and sexuality, and not simply *either* privileged *or* penalised. An example is a white woman who is assumed to be privileged in terms of race but penalised in terms of gender. Another example is that of a white homosexual man who is assumed to be privileged in terms of race and gender, but penalised in terms of sexuality. No one person, whether female or male, then, is simply a victim or an oppressor in this system. This opens up thought to many possibilities based on not privileging one axis of oppression but incorporating multiple axes, and so aids plurality in thinking. The binary gender perspective of female/male is replaced with a framework allowing for multiple positions.

Also, this model is structured on three levels: the level of personal biography; the group level of the cultural context; and the systemic level of social institutions. Individual biographies are made up of 'concrete experiences, values, motivations, and emotions' (Collins 1991, p. 227). Each biography is rooted in several overlapping cultural contexts, such as groups defined by race, gender and age. The third level of the model concerns social institutions, for example, the media, schools and other formal organisations. Within the matrix of domination, Collins (1991) states, each individual derives varying amounts of

penalty or privilege from the multiple systems of oppression. Collins' model does not consider gender to be constrained to fixed patterns. Rather, the concepts of difference and context are integral to understanding gender.

### Postmodernist Explanations

Note: Fawcett and Featherstone (2000) state that the relationship between poststructural and postmodern perspectives is not clear-cut and that there are many views regarding whether poststructuralism and postmodernism can be seen to relate to similar broad areas. Fawcett and Featherstone (2000) suggest that the term 'postmodernism' may be used to represent postmodernism and poststructuralism. It is in this sense that I use the term 'postmodernism' in my study.

Postmodernism has influenced both social work theory and feminist theory in recent years. It raises interesting questions in social work theory and this area will be briefly studied in this section. Postmodernism and feminist theory will then be examined.

Postmodernism objects to the modernist conception of language as a transparent medium which grants humans access to unmediated reality. Instead, it considers that reality is an effect of language and that there is no absolute 'truth' to be found. Language is social, and so it is intricately involved in the power relations of human society as well as in social work interactions. This raises questions such as who makes up social work realities, what are the interests and who benefits (Rossiter, 2000).

Postmodernist approaches suggest that social work theory is an outgrowth of an Enlightenment inheritance which calls on 'truths' that seek to provide unitary explanations of human nature (Rossiter, 2000). This type of thinking holds to ideas, such as, a view of the subject as powerful and self-consciously political, a belief in reason and rationality, and a belief in social and economic progress. This could be a description of social work and the discipline of social



administration at the beginning of the twentieth century (Williams, 1996). Postmodernism has led to much questioning of social work 'truths' through its distrust of metanarratives. In place of these, postmodernism focusses on difference, fragmentation and heterogeneity (Schwandt, 1997).

The postmodernist project has brought the question of power to centre stage in terms of social work theory. The professional perspective of a social worker can no longer be seen as simply unfolding the 'truth' of a service user's situation. Instead, there is the negotiation of two views, that of the worker and that of the service user.

Postmodernist social work insists that social workers are socially located in specific historical and social spaces. Thus, their knowledge is a partial perspective which is tied to their social location. Understanding that knowledge is dependent on the knower abolishes reliance upon models and schemas for decoding human behaviour (Rossiter, 2000). This type of postmodernist theorising is usefully drawn on in my study. It is also pertinent to include as recent relevant theoretical developments in the field of social work theory. Postmodernism has also had an influence on feminist theory and in similar ways to social work theory.

Fawcett and Featherstone (2000) state that feminism has been historically and theoretically a modernist movement. Both liberal and socialist feminisms, despite their differences, have stemmed from the emancipatory impulses of modernism.

Modernist thinking, which is rooted in the ideals of the Enlightenment, is the basis of nineteenth- and twentieth-century political and social theories, such as those of Marx and Weber. These focus upon grand theory and involve a quest for universal truth. Underlying such theories is a way of analysing the world in terms of oppositional categories, such as woman / man (Williams, 1996).

Feminism is part of the impulse of the Enlightenment and also part of the critique of the Enlightenment thinking (Williams, 1996). New wave feminism

challenges the Enlightenment's conception of distinguishing truth and falsity from an external point. It points instead to the social construction of a dominant form of masculinity which means that speaking and hearing become activities of gendered content (Ransom, 1993). It is not possible from this theoretical viewpoint to stand outside gendered behaviour or to have an 'external point' from which truth and falsity can be distinguished.

Orme (2001) states that the developments within feminism which focussed on recognising differences between women were coterminous with postmodern and post-structural rejection of a unified subject as the agent of social or political change. The concept of difference was highlighted rather than that of unity. According to Trinder (2000), postmodernism moves feminist theory towards examining the different voices women and men are using within the context of unequal gender, and other social relations.

Postmodernism encourages a shift in perspective away from grand theory towards accounts of gender relations in specific contexts and locations (Featherstone and Trinder, 1997). It also questions categories, such as 'women' and 'men' and their relation to each other. The construction of differences within as well as between categories is examined, for example, within 'masculinity' as well as between 'masculinity' and 'femininity'. In terms of power, gender relations are forms of domination, according to Featherstone and Trinder (1997), but ones with no fixed pattern. Hence, the focus moves from the clear-cut notions of oppressors and victims of some feminist theorising, and towards examining how masculinities and femininities are constructed and operate in relation to one another.

Gender relations, then, involve power in the postmodernist perspective in a shifting and fragmented way rather than in a uniform sense. Women are in differing power positions in relation to other women, to men and to children (Featherstone, 1997). Postmodernism shifts away from dualist thinking, for example, woman / man, and towards an understanding of the multi-faceted nature of identities and phenomena (Williams, 1996). Theorising of gender from a postmodernist perspective takes account of these differences in relation to

specific historical contexts and locations, and my study has been influenced by such theory.

The postmodernist and black feminist approaches, then, encourage a focus on the complexity of the social relations of gender and form part of the theoretical basis for my study.

### **SECTION 3**

#### **Interactions: Mental Health, Gender Differences & Work Organisation**

##### *Social Work Organisations*

The work organisations of Mental Health Officers are Social Work Departments. The topic of gender will be examined in relation to work organisations, specifically Social Work organisations.

Itzin (1995) maintains that gender is an integral factor within work organisations, and that these organisations contain a 'gender culture' which is hierarchical, sex segregated, sex stereotyped, sex discriminatory and resistant to change. This gender culture is not accidental and has been shown to be related to the ways in which women are systematically denied access to important organisational networks (Itzin, 1995).

Witz (1992) locates work-related gender differences in the wider political context and draws on dual-systems theory which argues that patriarchy, as well as capitalism, structures gender divisions at work in modern Western societies. She argues that this theory overturns the conventional view that gender divisions in employment can simply be read off from those in the family. However, the persistence of job segregation by sex in the labour market, and of a gendered division of labour within the household, means that women participate in the public sphere on different terms than do men. For instance, women's jobs tend

to be more threatened than men's jobs because many of the former are part-time or low-skilled.

The issue of the female worker's position being secondary in different ways to that of the male worker is raised by both of these authors, Itzin (1995) and Witz (1992). The gender culture of work organisations and the structuring of gender divisions at work may result in Mental Health Officers' awareness of gender-differentiation in their departments.

Hudson (1989) points out another problem which female workers often have to deal with. She argues that women workers must continuously negotiate the conflicting demands of home and work. Even though female social workers may be able to access child care and other forms of domestic support, she argues that this does not prevent the female social workers from having to manage the boundary between home and work. For example, when a child is ill it is women who are more likely to take time off work in order to care for the child.

In the social work profession, gender segregation exists both vertically and horizontally (Howe, 1986). Vertical segregation involves, for instance, more men at director level and more women at social worker level in the Personal Social Services. Horizontal segregation involves different proportions of female and male personnel in the various areas of social work, such as child and family work, and work with older people. Howe (1986) states that women predominate throughout all branches of residential work, for example, but are particularly prevalent in caring for older people. He argues that managing is regarded as men's work and caring as women's work, and that this difference accounts for both horizontal and vertical segregation of women.

The vertical and horizontal segregation of women is a function of the same mechanism of discrimination that recognises different types of work as suitable either for men or women (Howe 1986, p.33).

Hudson (1989) similarly argues that women social workers are regarded as utilising supposedly 'natural' capacities to care. As Cree (2000) argues, ideas of women's 'natural' capacity to care lead to harsh judgements of those women

who do not live up to the stereotype. This suggests that female social workers who do not live up to the stereotype may receive harsh criticism from, for instance, other social workers who hold to ideas of women's 'natural' capacity to care.

Tomaskovic-Devey (1995) makes a useful distinction between the 'dual processes of segregation', in terms of being 'allocative' or 'valuative'. 'Allocative' refers to women being channelled into less desirable jobs. 'Valuative' refers to the social devaluation of women's jobs including the attendant skills and responsibilities those jobs demand. For example, 'allocative' could refer to cleaning an office building as a less desirable job than being the office manager. 'Valuative', in that instance, could refer to the social devaluation of the job of cleaning and its attendant skills and responsibilities of cleaning and maintaining the office building.

Women dominate numerically in social work, both as workers and as service users, and also the majority of concerns are gender-related, for instance, mothering children (Christie, 1996). Therefore, social work could be said to be a 'female' field of work in various ways. However, some men enter social work and often gain quicker promotion than women. Cree (1996) found from exploring why men and women choose to become social workers, that men entering social work mostly expect to be promoted sooner than women, and also that women acknowledge men's promotion prospects to be better than their own.

Jacobs (1993) considers that for men the choice of a female-dominated field is quite uncommon and rarely endures for long. However, it has been argued that the effects of sexism can outweigh the effects of tokenism when men enter non-traditional occupations (Williams, 2000). In other words, despite being numerically a small percentage in, for instance social work, men can gain over women because of gender considerations. It is the social status of the 'token' which matters. Prejudice faced by men in such occupations, Williams (2000) states, usually comes from outwith these occupations, such as the pressure of negative stereotypes, for example, being seen as 'failures'.

Christie (1996) conducted a research study interviewing twelve men social workers and found that ten out of the twelve men perceived a need for 'gender balance' both in the working of social work agencies and in their work with service users. Gender balance, Christie (1996) suggests, is employed as a strategy for justifying men's presence in the non-traditional occupation of social work. Gender balance is related to numbers of women and men social workers rather than to gender power relations within the team. Often, gender balance is implemented in social work by men working with men service users, and the co-working of women and men social workers with families.

Social work, overall, seems to contain Itzin's (1995) gender culture given the evidence for differential treatment of women and men workers, including the aspects of promotion and the different areas of work which are seen as suiting women or suiting men. Such a gender culture is of relevance to my study, both generally in terms of social work and specifically in terms of mental health social work.

A social work organisation holds many responsibilities including decisions on who can carry out what work and the main functions and tasks of various posts, as well as the structure of departments. Several writers suggest that the issue of gender cannot be dismissed from the structuring and functioning of work organisations, including social work organisations. Gender relations are involved in my study not only between social workers and service users but also between colleagues as well as inter-agency working. Each of these areas of relating is integrally involved in the implementation of the mental health social work role. The personal area of gender relations is also included where it overlaps with professional responsibilities.

### *Mental Health and Gender Differences*

Statistical data indicate that there is strong evidence of gender-differentiation in relation to mental health. This was outlined in the previous chapter. Pugliesi (1992) cites one of the more consistent findings of epidemiological research



which is that women experience higher rates of psychological distress and depression than men do.

Brown (1987) reports on a programme of research which began in 1968 on the social origins of clinical depression. This concluded that lack of an intimate tie with a husband, having three or more children under the age of 14 living at home, and loss of a mother before the age of 11, all act as vulnerability factors for women – that is, that risk of depression is increased in their presence once a provoking agent such as loss or disappointment occurs.

Department of Health and Social Security (DHSS) figures for admissions to hospitals and units in 1986 show that many more women than men were admitted for many diagnoses (Burns, 1992). This research also suggests variation across categories between the sexes; for example, women are much more likely to be diagnosed with affective psychoses and men are slightly more likely to be diagnosed with schizophrenia. This is of relevance to my topic in terms of the interactions of Mental Health Officers with a service user group which is differentiated between the gender groups in relation to mental health.

Ramsay et al. (1996) state that men are less able than women to seek help from professionals or to gain support in social networks. There are also particular grounds for concern about men's mental health, such as the poorer prognosis for men with severe mental illness. They suggest that mental health professionals need to direct attention to men's mental health problems which they may currently be missing. Miller and Bell (1996) point out the much greater risk of suicide linked to men of all age groups than to women.

There are, however, complicating factors in relation to this presentation of gender differences. Busfield (1996), for instance, argues that the diagnostic criteria of official psychiatric classifications of mental disorders have a formal gender-neutrality. That is, they are designed to allow them to be applied to either women or men – to be neutral regarding gender, class, ethnicity and so on. This formal gender-neutrality does not mean that the categories themselves are constructed independently of gender, she argues, because the official categories

refer to many aspects of mental life and behaviour which are themselves gendered. Gender-neutrality, then, is impossible apart from at the surface level. Busfield (1996) suggests an indirect relation between gender and the official constructions of mental disorder.

Mental health is regarded as 'feminine', according to Busfield (1996), in that mental distress is assumed to be beyond the control of the person who experiences it. In this perspective, mental distress is assumed to be irrational.

For example, to the extent that fear, anxiety and sadness are deemed more appropriate, reasonable feelings in women than in men, then the categories of disorder constructed around pathologies of these feelings will end up identifying more female than male disturbance (Busfield 1996, p.103).

She further argues that men's mental life and behaviour, if and when they are deemed problematic, are more likely to be regulated through judgements of wrongdoing, and women's through judgements of mental disorder. In other words, men are more likely to be dealt with by the criminal justice system and women are more likely to be dealt with by the mental health system. She argues that the realm of wrongdoing or deviance is one where people are thought to be agentive or active (rational), and the realm of mental disorder is one where individuals are assumed to be subject to forces beyond their control (irrational). Busfield (1996) maintains that it is this opposition which links men with the rational and women with the irrational, and underpins the tendency to constitute the boundaries of mental disorder to include more of the terrain of women's than men's problems.

Also, it has been argued that conceptions of mental illness are closely related to cultural constructions of femininity (Pugliesi, 1992). Burns (1992) states that within our present gendered discourses, women are expected to be unstable. She argues that gendered assumptions have been institutionalised, for example, through the discourse of psychiatry.



There are, then, various arguments linking gender with psychiatric diagnosis or classification. McBride (1990), though, is interested in roles and how these affect mental health, specifically to explain gender difference in mental health. She highlights a relation between women's multiple roles and levels of mental distress. She states that the anecdotal evidence for this link is extensive. McBride (1990) argues that it may not be the burdens within women's role which lead to stress so much as the ability, or lack of it, which women feel in choosing that role.

Simon (1995) suggests that work and family roles have different meanings for females and for males, and that these differences may be partially responsible for why the mental health advantages of combining multiple roles are fewer for women than for men. For instance, he found in a research study that wives feel responsible, and husbands hold them accountable, for marital problems that are created when both spouses combine multiple roles.

Overall, there are various explanations concerning mental health and gender differences which form the theoretical basis of this area. These include theorising that psychiatric diagnosis or classification and gender differences are linked; that specific consideration needs to be given to men's mental health; and that women's and men's roles are related to mental health which, particularly in the case of women, leads to higher levels of mental distress.

### *Mental Health, Gender Differences & Work Organisation*

As stated earlier, most social work service users are women or children, and the majority of social workers are female (Christie, 1996). The social work sphere, then, might be viewed as a predominantly 'female' area of work from this perspective. This sphere includes mental health social work as part of the broader social work context.

From a historical perspective, however, and in relation to mental health nursing, Dingwall et al. (1988) note that asylum work was dominated by working-class men. They argue that this was partly because of the need for physical strength if

patients were required to be forcibly restrained. Also, Dingwall et al. (1988) state that the conditions of service, particularly the social isolation and low regard for the patients, deterred the small number of more educated women from entering 'mental nursing', as they preferred general nursing. Therefore, it seems that male workers dominated mental health services at the time of 'the asylum'.

Howe (1986) carried out research involving 285 fieldworkers in three social services departments and notes that 60% of workers with a heavy bias towards working with 'mentally ill and mentally handicapped' (p.24) people were men, although numerically men were a small percentage of the whole sample. Howe states that male workers are less likely to enter into dependent caring roles within social work. The suggestion seems to be that mental health work is not regarded as dependent and caring, and so is more likely to attract male workers. Christie (1996) makes a similar observation, stating that in the 1990s men tend to be found in managerial positions or social work positions with higher status, such as mental health.

Hudson (1989) also notes that those tasks which involve authority and control seem to be more attractive to male social workers than are other areas involving care of dependent people. These writers, then, tend to group 'men' social workers together in making such observations.

Cree (1996), though, found that male social workers regard themselves as having embraced feminine characteristics and so see themselves as different from other men. I think that this indicates that differences occur within groups as well as between groups.

There are, then, various arguments regarding whether or not differences between female and male social workers occur in terms of mental health work. For example, are female workers less attracted than male workers to mental health work? Are female workers less interested and comfortable in positions of authority and control than are male workers?

Female and male Mental Health Officers may have different and overlapping views of mental health social work, views such as the relevance or not of gender differences, including their own personal gender.

### *My Approach to this Complex Subject*

As previously stated, my study aims to explore meanings of gender from the views of Mental Health Officers which relate to their professional role as mental health social workers and to their being part of a social work organisation. Also, taken into account are personal views of the Mental Health Officers which overlap with their professional responsibilities.

I have found the most useful approaches to develop my research study to be sociological explanations, as well as feminist and postmodernist theorising. I have also examined biological and psychological explanations. However, I have not found those explanations so convincing because they seem, respectively, to reduce the complexity of human experience to one dimension, and to be unable to adequately account for differences, for instance, within the groups 'women' and 'men' as well as between these groups. I have argued that explanatory arguments need to adequately account for these differences.

The explanatory material I have covered for the ways in which mental health and gender differences are related includes arguments that gendered assumptions have been institutionalised, for instance, through the discourse of psychiatry, and that women's and men's different roles influence levels of psychological distress.

The perspective of my project is that gender and mental health are socially constructed, that is, meanings of gender and mental health relate to historical and social contexts. Assumptions concerning gender and mental health on the part of Mental Health Officers are taken into account. Orme states:

Assumptions inherent in constructions of femininity and masculinity are germane to the diagnosis of individuals experiencing symptoms

associated with mental health problems and are significant within assessments for community care which influence treatment decisions and resource allocation (2001, p.131).

Orme (2001) also points to the involvement of a variety of professionals and lay people in the operation of community care and argues that this varied involvement highlights the need to understand their constructions of gender. Social workers in the mental health field, for instance, are gatekeepers of definitions and understandings as well as of resources. Hence, Orme (2001) states, gendered assumptions may become significant in assessing whether a situation warrants service and also what kind of services will be allocated. These gendered assumptions are of relevance to my project in terms of studying the perspectives of Mental Health Officers.

I have argued that social constructionism accounts for differences among women, among men, and between women and men, as well as in relation to cultural and historical contexts. Feminist social constructionist perspectives tend to take gender as produced and reproduced in interactions with others. In my view, theorising gender from a social constructionist perspective takes into account the concept of difference within the context of interaction. This concept is very important to black feminist thought and also to postmodernist thought.

My study has drawn on the social constructionist perspective and specifically on Collins' (1991) multiple axes model. Both black feminist and postmodernist influences are found within Collins' (1991) model. This model is useful in relation to the concept of gender within my own study and for a number of complementary reasons. The model regards axes of oppression as interlocking and it incorporates the concept of difference, viewing the individual as neither victim nor oppressor but as both privileged and penalised in terms of the systems of domination. It also leads in my study to Mental Health Officer participants' being viewed as individuals with personal biographies; as part of a group defined by gender (as well as part of other groups); and as part of the social institution of a Social Work Department. Personal and professional, as well as cultural contexts of gender and other axes, are taken into account. I think that this is one of the strengths of my study, that each of these areas is included.

These areas specify the interactions of my project. Gender is studied in relation to other axes. Each informant is regarded as an individual with her/his own personal experience, and also professional experience in the role of Mental Health Officer. This individual is also part of a group defined by gender, as well as being an employee or part of a working organisation. In other words, the approach of my study is to open up gender in the context of Mental Health Officer experiences by utilising these areas and points of interaction.

Social constructionism, then, helps to explain gender differences in relation to both mental health and work organisation, and specifically in the context of mental health social work.



## **CHAPTER 4**

### **METHODOLOGY**

#### **SECTION 1**

##### **Introduction to Chapter**

The aim of my project is using the perspectives of informants to explore meanings of gender in relation to the Mental Health Officer role. The methods and techniques used are established within qualitative research, for instance, data reduction, data display and conclusion drawing / verification as a substantial part of data analysis, and advocated by Huberman and Miles (1994).

This chapter begins with an outline of the principal tenets of feminist research contrasted with those of the more established positivist tradition. I have chosen a feminist-informed methodology for my project and my reason for this was methodological effectiveness to the subject matter in hand. Feminist methodology focusses on the topic of gender, and so it is drawn on in order to open up the area of gender in terms of the Mental Health Officer role.

The methods and techniques utilised in my project as well as the reasons for adopting them are covered in this chapter. This includes sampling, interviewing as a data collection technique, and the 'stages' of data analysis.

There are two main differences in emphasis between feminist and other qualitative research approaches. The first is the primary interest in gender, whereby gender is taken to concern the categories 'men', 'male', and 'masculine' as much as the categories 'women', 'female', and 'feminine'. This

interest will be examined in depth in this chapter. The second is in the emphasis on reflexivity, and again this will be examined in this chapter.

## **Social Science Research Background**

The positivist paradigm has been established for four centuries (Guba and Lincoln, 1994). The feminist paradigm, on the other hand, developed much more recently, within the last few decades. Feminism may be regarded as one of the alternative approaches to that of positivism, according to Guba and Lincoln (1994).

### **Positivism**

The term 'positivism' is traced to August Comte (1798-1857). It denoted a philosophy of strict empiricism whereby the only legitimate knowledge claims are those founded on direct experience (Schwandt, 1997). The newer social sciences followed the positivism of the established physical sciences, and assumed that the social world could be measured and analysed in much the same way, that is, through direct observation of 'social facts'.

Positivism has dominated the formal discourse in the physical and social sciences for some 400 years. It has, however, been transformed over the course of the last century into postpositivism. The postpositivist approach holds to essentially the same set of basic beliefs as positivism, though it attempts to respond to the most problematic criticisms of positivism. For instance, the ontological view of positivism is that reality is apprehendable, whereas postpositivism regards reality as imperfectly apprehendable (Guba and Lincoln, 1994).

Although there are such differences between positivism and postpositivism, it seems they can be regarded for consideration here as one overall paradigm.

### Positivist Methodology

The methodology of positivism is experimental and manipulative. Propositions are subjected to empirical tests in order to verify them. The positivist approach holds that reality can be observed by the human senses, and that the truth of statements which correspond to real objects can be determined by observation. It is assumed that there is order in this reality, and that regularities between observed events or objects constitute general laws. Positivism rejects all theoretical or metaphysical notions that are not derived from experience or the evidence of the senses (Blaikie, 1993).

Guba and Lincoln (1994) state that the aim of inquiry is explanation, ultimately enabling the prediction and control of phenomena, whether physical or human.

A fundamental tenet is that of the 'unity of scientific method' (Blaikie, 1993). Also, the origin of scientific problems or hypotheses is considered irrelevant. Rather what matters is the testing process. A working code of good practice has been established to include the following: results must be generalisable; data collection methods are to be objective, valid and reliable; a logic of experimentation in research design must be present (McGlew, 1998).

### **The Development of Feminist Research**

#### Feminist paradigm – background

The feminist paradigm is still in its formative stages, and no final agreements have been reached concerning its definitions, meanings or implications (Guba and Lincoln, 1994). Any feminist, or feminist-informed study, needs to take this into account as the theoretical background. My project, consequently, draws from the feminist paradigm as it stands in its present, and developing, form.



There are, however, feminist values and principles which will be examined and incorporated.

Harding (1987) identified two feminist research perspectives. The first is feminist empiricism, which argues that male-centred biases within scientific inquiry need to be eliminated by the stricter use of methodological norms. The second is the feminist standpoint, which is interested in knowledge based on the experiences of women as an oppressed group.

Harding (1987) raises the point that both of these approaches assume that feminist inquiry will produce a narrative about social life. Both the black feminist and postmodernist perspectives argue against this. Black feminism argues that there is not one unitary feminist perspective since women's experiences differ by race, class and culture. Postmodernism, Harding (1987) argues, holds that there are many stories women tell based on their different knowledges.

Olesen (1994) similarly states that views of women's lives and assumptions about their subjectivity were once seen by some as universally homogeneous. However, African American scholars, such as Angela Davis (1978), have criticised white feminists unexamined use of a woman or women as standing for all women (Olesen, 1994). Lesbian women and disabled women have also made critiques of such representation from their own perspectives (Cree, 2000).

In the last few years there have been various developments in feminist research theory through the impact of black feminist thought (Collins, 1991) and also postmodernism (Cavanagh and Lewis, 1996). Homogeneity has been challenged. Reinharz (1992), for example, argues that a feminist research project needs to take account of diversity. Black feminism focusses on differences between women and postmodernism pays attention to fragmentation and difference. This focus dissolves meta-narratives, and highlights instead individual narratives and multi-faceted stories.

Also, Foucault's analysis of power as ever present and productive of knowledge has influenced some more recent feminist theory, such as Ramazanoglu (1993), and also some more recent feminist social work theory, such as Healy (2000). Earlier feminist theory, on the other hand, tended to regard gender as a social structure of generalised oppression of women, incorporating an oppressor/victim structuring of power.

There is not, then, *a* feminist research perspective (Reinharz, 1992). There are multiple feminist perspectives on research methods, as similarly there are multiple definitions of feminism, such as socialist, radical, liberal, black feminism, and postmodernist feminism. The study of gender has developed as a result of feminist theoretical perspectives.

The concepts of critical theory, such as gender as social structure and the linked perspective of feminism as emancipatory, are challenged through the influence of the newer schools of thought. Guba and Lincoln (1994) state that the aim of feminist inquiry is the critique and transformation of constraining social structures. However, postmodernism has challenged social structural theory and the hold of such meta-narratives. Consequently, emancipation or political change as a feminist aim has been challenged by the postmodernist project and though it used to be considered the goal of feminist research (Hammersley, 1995), emancipation is not necessarily an aim of such research today.

Gottlieb and Bombyk (1987) also query the goal of emancipation on the basis that an aim of social change might distort knowledge-building by, for example, the rejection of answers that do not meet intended political aims.

Feminist research is, therefore, undergoing considerable theoretical argument and development at present though its principal interest in gender remains. Analysis is generated from theorising phenomena as gendered and embedded in power relations, according to Reinharz (1992).

Feminist research may be regarded as one of the alternative inquiry paradigms to positivism in that it holds to the assumption of the value-determined nature of

inquiry whereby values are seen as shaping inquiry outcomes (Guba and Lincoln, 1994). Positivism, on the other hand, is concerned in social science with attempting to discover social facts or essentials (Silverman, 1993).

Feminist research incorporates subjectivity (Oakley, 1981) rather than the objectivity of positivism since the research process is regarded as value-laden, not value-neutral. The objectivity associated with the positivist social research view is reconceptualised by feminism as an approach to inquiry making use of subjective experience. The inclusion of subjectivity is the principal difference between positivism and feminism.

Mauthner and Doucet (1997) point out that feminists have argued for over two decades that understanding and knowledge come from being involved in a relationship with the subject matter and informants, and not by adopting a detached and objective stance.

Value-free neutrality is not sought, and so the stable comparisons usually associated with positivist, particularly quantitative, methods are not part of the qualitative methods used in my study.

A consequence of this feminist view is that reflexivity is central to feminist research. Harding (1987) states that the inquirer has to be placed on the same critical plane as the overt subject matter, that is, the informants in my study. Harding (1992) argues that knowledge production should contain an examination and explication of researcher beliefs, biases and social location (Mauthner and Doucet, 1997). Reflexivity arises from a non-objective stance that seeks to see how values and interests affect the research process from, and because of, the researcher's viewpoint.

The subjectivity of experience, and reflexivity, then, are underlying theoretical principles to feminist research (Harding, 1987).

### *Feminist Methodology*

Feminist methodology, in contrast to that of positivism, is dialogic and dialectical because the interactive nature of its' inquiry requires a dialogue, dialectical in nature, between the investigator and the investigated (Guba and Lincoln, 1994). Although no single feminist methodology exists (Cavanagh and Lewis, 1996), distinct feminist methodological features have been identified (Harding, 1987), and now seem to be widely accepted (Mauthner and Doucet, 1997). These methodological features form the basis of the methodology of my project, in addition to the influence of black feminist thought and postmodernism.

The methodological principles guiding my project are: 1. The experiences of women, as well as of men, are a valid focus of study. 2. Reflexivity in the research process means reflecting upon and understanding the researcher's social location in relation to the informants, and also acknowledging the critical role the researcher plays in creating, interpreting and theorising research data (Mauthner and Doucet, 1997). These two principles will be examined in the following section.

Feminist research has taken women's experiences as its starting point. This is to counter the perceived male bias of social science generally. Harding (1987) states that it is because of the lack of understanding of the participation of women in social life within traditional (positivist) social research, that feminist theorists have argued for a perspective based on women's experiences and an analysis of gender. It may, however, be maintained that the androcentric criticism is being responded to within mainstream social science research, particularly qualitative, through the inclusion of gender on a general basis. I would argue, though, that the feminist approach adds to research knowledge through its focus on research problems, and the research process itself, in terms of gender.

It may also be argued that reflexivity is becoming more of a routine requirement in qualitative social research generally. It is, though, a specific methodological feature of the feminist perspectives (Harding, 1987).

The concepts of experience and reflexivity are complex ones within feminist research and these are included for further examination in the next section.

## **SECTION 2**

### **The Methodology of this Study**

Five aspects of the methodology will be considered in this section, in relation to my research project. (These include the methodological principles of 'Experience' and 'Reflexivity' as highlighted in the previous section.) The five aspects in order of presentation are as follows: female and male informants (Wolf, 1996; Harding, 1993); experience (Stanley and Wise, 1993; Holstein and Gubrium, 1994; Harding, 1987; Hammersley, 1995); reflexivity (Wasserfall, 1997; Hammersley and Atkinson, 1983; Altheide and Johnson, 1994); black feminism and postmodernism (Collins, 1991); power differentials (Mauthner and Doucet, 1997; Hammersley, 1995; Wolf, 1996; Reinharz, 1992; Cavanagh and Lewis, 1996).

Feminist research is an eclectic approach incorporating various types of feminist thought, such as radical, liberal, black and postmodernist, as well as the different methodologies of qualitative and quantitative. This means that feminist researchers need to choose from this broad approach the elements which underpin and develop their projects, and which are consistent with each other in feminist terms.

The approach I have taken is to interpret the views of Mental Health Officers, based on experiences relating to mental health social work, in relation to the axis of gender. The personal and the professional aspects of views, as well as the

cultural context of gender, are taken into consideration. I have compiled this approach using the resources of feminist research theory, some of which have adopted and adapted resources that are outwith feminism, such as Schutz' phenomenology (Stanley and Wise, 1993).

The different aspects of this methodology are useful in various ways:

1. Studying gender using female and male informants means that data is produced on both gender groups, and this is particularly relevant for the less-researched male gender.
2. Theorising of experience as a concept allows for contrast between experience and categorisation. Stanley and Wise (1993) utilise Schutizian phenomenology in a feminist understanding to contrast categorisation with experience, for example, the categories 'women' and 'men' with the experiences of women and men.
3. Utilising reflexivity aids analysis in feminist research. Reflexivity is a specific methodological feature in the feminist tradition (Harding, 1987). The feminist approach views research as value-laden and utilises reflexivity to expose the research process, including researcher values and interests.
4. Resources drawn on include black feminist theory, particularly Collins' (1991) interlocking axes model of oppression, and postmodernism especially in relation to the concept of difference.
5. Power differentials are highlighted relating particularly to gender.

The methodology, then, of my project is drawn from the wide-ranging feminist approach, which consistently holds to gender as the topic of interest.

### **1. FEMALE AND MALE INFORMANTS**

The term *feminist* might be thought of as suggesting that the interest of my project is in the gender categories 'female' / 'feminine' / 'women'. However, my study is as interested in the gender categories 'male' / 'masculine' / 'men', and since it is the study of gender which is the interest of feminism, I have held to the term 'feminist' in the project.



Harding (1987) states that traditional (positivist) theories have been applied in relation to men in ways which aim to give meaning to 'the human'. She points out that men's activities are gendered. Feminists are now researching the gender of men as well as of women. For instance, Cavanagh and Lewis (1996) have researched 'violent men'. Also, black feminist thought, (Collins, 1991; Hooks, 1990) with its emphasis on differences, for example, differences among women, and among men, as well as between women and men, can be applied to research such as my own study since it includes both women and men as informants.

Researching men as well as women has been problematised in feminist theory. The focus of much discussion is on women as the subjects of feminist research. Wolf (1996) suggests a shifting research agenda of 'studying up', that is studying those with power and control. Scott and Shah (1993) encourage this type of investigation as it may partially solve the problems of power inequalities and exploitative research relationships which could result from these (Wolf, 1996). They suggest that it may also help us to learn about social constructions from different perspectives, for instance, we can learn about the social construction of race and racism differently when studying people of colour and white people. Similarly, I think that we can learn about the social construction of gender by studying men as well as women.

In my view, the concentration of feminist research studies using women as informants has needed to be balanced with studies using men as informants, and this has begun in qualitative research, including my own study. In criticising feminist research that concentrates on women's lives, Harding states:

...research processes that problematize how gender practices shape behaviour and belief – that interrogate and criticize both masculinity and femininity – stand a better chance of avoiding such biasing gender loyalties (Harding 1993, p.60).

One of the strengths of my project is that it contributes to the study of gender in relation to mental health social work, from the perspectives of men as well as of women. This interest in gender relating to both men and women, is apparent in all 'stages' of the project, for example, in the sample consisting of both male and

female informants; and in the design of the interview schedule which included questions concerning the gender of men, and also of women, for instance, the following question focussing on the gender of men in relation to mental health problems:

*What do you think of the following statement: 'The mental health problems of men should be considered from the perspective of gender discrimination as much as the mental health problems of women'?*

Primacy of gender in the research process is queried by Hammersley (1995) as possibly stripping away other relevant aspects of a phenomenon and its context. However, feminist research now tends to emphasise diversity (Reinharz, 1992), and the need to take into account other aspects of a phenomenon and its context, such as race, sexual orientation and class. My own project involves such other aspects, for instance, utilising Collins' (1991) interlocking axes model of domination encourages the focus of analysis on to several dimensions. This model will be looked at in the next section regarding the concept of experience.

## 2. EXPERIENCE

Subjective experience is central to the study as a concept, not only the experience of informants but also the experience of the interviewer. Reflexivity is a methodological principle which opens up and critiques the interviewer's views based on experience, in relation to the informants' views based on experience. It is part of the research processes of my project.

Experience will now be examined in terms of its relevance to my study. Categorisation and how it relates to experience will also be explored. For instance, categories relating to gender such as 'women' and 'men' will be explored in relation to experience, as will categories relating to the Mental Health Officer role such as 'personal' and 'professional'. Schutzian phenomenology is drawn on to explore categorisation and experience and it is utilised in a feminist approach as advocated by Stanley and Wise (1993).



### Schutzian Phenomenology

Alfred Schutz (1899-1956), drawing on the phenomenology of Edmund Husserl (1859-1938), developed a phenomenological foundation for Weber's idea of meaningful social action. The emphasis on action reflects two important ideas: that the acting individual attaches subjective meaning to her or his behaviour; and that understanding subjective meaning requires understanding not simply individual beliefs but also intersubjective or shared meanings. Subjectivity, then, is assumed to be constituted intersubjectively (Schwandt, 1997).

Schutzian phenomenology develops these ideas further. Schutz noted that an individual approaches the life world – that is, the experiential world every person takes for granted – with a stock of knowledge which is social in origin. This *stock* is composed of constructs and categories, and these are resources with which:

persons interpret experience, grasp the intentions and motivations of others, achieve intersubjective understandings, and coordinate actions (Holstein and Gubrium 1994, p.263).

The constructs and categories are known as *typifications*, and these are guidelines for understanding and interpreting experience which are both general and flexible. Typifications make sense of things and occurrences as being of a particular type, though they are always indeterminate and modifiable. Stocks of knowledge are not closed off but are always incomplete.

Meaning requires the interpretive application of a category to the concrete particulars of a situation (Holstein and Gubrium 1994, p. 263).

Schutz' argument that consciousness necessarily typifies rests on language as the medium whereby typifications and therefore meaning are transmitted. This phenomenology of social life provides a methodological orientation concerned with the relation between language use and experience. It does not follow a correspondence theory of meaning which aims to describe reality, rather it rests on the tenet that social interaction constructs as much as conveys meaning.

Stanley and Wise (1993) draw on phenomenological sociology in their theorising of social research. They argue that in Cartesian frameworks a hierarchy exists between the category or typification and the experience that the category supposedly relates to, whereby when experience and category are unsynchronised there is a tendency to assume that experience is somehow faulty. An example where a fracture may arise is the experience of being a woman and the categorisation of what it is to be a woman. A categorisation necessarily typifies and is not able to completely account for diversity and difference.

Stanley and Wise (1993) suggest that feminist theory should focus on the multiple and continual fractures which occur between experience and categories. Given that Schutz' approach considers meaning as arising from the interpretive application of a category to the concrete particulars of a situation, and that categorisations are always incomplete, there is potential for categories to not 'fit' experiences. How sense is made of these fractures is part of the methodological approach of my study, specifically in relation to gendered categories, such as 'women' and 'men'. These are critically analysed in terms of their application in constituting meaning and fracturing of meaning.

I have rejected representational principles which see the category 'women' and the experience of women as synonymous since this takes no account of difference between and across groups of women. My study uses the methodological principle of Schutzian phenomenology concerned with the relation of language use and experience, and specifically is interested in fractures between categorisation and experience as suggested by Stanley and Wise (1993).

The interlocking axes model (Collins, 1991) also emphasises that the experiences of both women and men are multi-faceted in relation to gender categories. As Harding (1987) states, gender experiences are often in conflict in any one individual's experience. The postmodern concepts of multiplicity and plurality, as well as that of difference, influence analysis in my own project. However, the centrality of 'subjectivity' and 'experience' to this method differentiates it from some postmodernist thought which centres instead on textual and linguistic analysis. Both of these concepts, 'subjectivity' and

'experience', are very important to much feminist research, and are part of my own study.

Hearn and Morgan (1990) point out there may be dangers of importing taken-for-granted understandings in using categories, such as 'women', 'men' and 'masculinity', and that terminology, for example, 'masculinities' should be used to emphasise the social construction of such entities. A conceptualisation of masculinity in terms of dominant forms and practices, for instance, heterosexual, white, middle class and so on, emphasises uniformity whereas the experience of masculinity and of being a man is not uniform (Hearn and Morgan, 1990). This suggests that categorisation may tend to subsume difference and diversity and I think that an emphasis on fractures between categorisation and experience breaks this down. I think that people do use categories in constituting meaning. An examination of these categories and their application is a necessary part of this methodology, taking a critical stance in relation to hegemony and taken-for-granted understandings.

Appeals to direct experience are criticised by Hammersley (1995) on the basis that all experience is a human construction. He argues that the approach of feminism, based on experience, needs to be reformulated to minimise the chances of false cultural assumptions being embedded in data. I argue, however, that this critique appears to be based on an assumption that there is an unproblematic and direct relation between experience and data collection as well as analysis in feminist research. Such an assumption of a direct relation is not taken in my study. Hence, the importance of reflexivity to expose values within the research process.

Hammersley (1995) also states that the importance placed on experience may encourage the treatment of some of the researcher's own experience and assumptions as beyond question when these actually require scrutiny. However, within much feminist research, including my own project, the emphasis on reflexivity and scrutiny of the researcher's standpoint, is intended to lead to the exposure of values, biases and assumptions which might otherwise be considered as simply part of the data. I would argue that the feminist

perspectives, through the centrality of reflexivity, attempt to 'open up' the research process as much as possible and that this is a strength of feminist research.

### *Personal and Professional*

The concept of experience is taken to include informants' personal as well as professional experiences that are relevant in exploring meanings of gender in the views of MHOs. Mental Health Officers are concerned with mental health issues in their professional role, however, mental health issues may arise in the informants' personal lives, for instance, in terms of the experiences of families and friends, or personally. This is not a concern with personal and professional as distinct and closed-off areas, but rather with the personal as overlapping the professional. Stanley (1991) suggests a lack of boundaries when she states that experience is anything with which the mind can deal.

### 3. *REFLEXIVITY*

Reflexivity as part of the research process needs to be critically analysed because of the important part it plays. Wasserfall (1997) points out that reflexivity is still ill-defined. She considers a 'weak' reading of reflexivity as epistemologically useful in terms of a continued self-awareness about the ongoing researcher's and informant's relationship.

Reflexivity is a position of a certain kind of praxis where there is a continuous checking on the accomplishment of understanding (Wasserfall 1997, p.151).

To take an example from my analysis, as researcher I ask questions such as: 'Am I making assumptions which are related to my social location, for instance, as a white and female researcher?' If so, the next step is to state and develop the meaning of the assumptions in the research process. That is, feminist methodology, unlike that of positivism, consciously uses value-related material as a research resource.

The 'strong' reading of reflexivity, however, Wasserfall (1997) argues has a tendency to gloss over difficult theoretical and political tensions in the research process because it contains assumptions concerning the deconstruction of the authority of the author and/or power difference. For instance, attempting to share interpretive authority between the author and the informants is a strategy to deconstruct the author's authority. This does not occur with the 'weak' reading.

This research project incorporates reflexivity in terms of the 'weak' reading, and does not deny that the role of the researcher includes some authority and power. Reflexivity is not used in the sense of somehow attempting to diminish these aspects of the research process, although it is recognised that claims towards authority and power are not held as unproblematic in the feminist perspective, and this will be considered later.

My project, then, encompasses the measure of validity based on *reflexivity*. This is quite often part of the process of current qualitative research, though, as stated earlier, it is widely accepted as a specific methodological feature in the feminist tradition. Harding (1992) argues that the production of knowledge must contain the systematic study and explication of researcher beliefs, biases and social location.

Hammersley and Atkinson (1983) define as one part of reflexivity, the consideration of the process of research and its possible implications for the validity of the main claims and conclusions of a study. This idea is taken further by Altheide and Johnson who term the evaluative standard based on reflexivity: 'validity-as-reflexive-accounting' (1994 p.489). This focuses on the interaction of the researcher, the topic and the sense making process.

All knowledge and claims to knowledge are reflexive of the process, assumptions, location, history, and context of knowing and the knower (Altheide and Johnson 1994, p.488).

This is an evaluative guiding principle of the methodology of my feminist-informed project, leading to the written research product as a reflexive account of the research process.

Reflexivity, in my view, makes overt the relation of contingency between all parts of the research process, according to researcher perspective. The researcher, in this feminist approach, presents an account which is dependent on social location and contextual specificity.

#### 4. BLACK FEMINISM AND POSTMODERNISM

My project, as stated earlier, draws on Collins' (1991) multiple axes model which regards axes of oppression as interlocking. The main points are that it is based on the conceptual stance of *both/and* rather than the western division of *either/or*. Consequently, any person can be seen as *both* privileged *and* penalised, for instance, in relation to axes such as race and gender, and not simply *either* privileged *or* penalised.

No one person, whether female or male, is simply a victim or oppressor in this system. This opens up thought to many possibilities not based on privileging one axis of oppression but on multiple axes, and so aids plurality in thinking. The binary gender perspective of 'female/male' is replaced with a framework allowing for multiple positions. This framework takes into account the multiple axes, such as gender, race, disability, and sexual orientation. Individuals are constituted as, for example: female, white, able-bodied, homosexual; female, black, disabled, heterosexual; male, black, able-bodied, homosexual; male, white, disabled, heterosexual.

The interlocking axes model (Collins, 1991) focusses analysis in my own study on to individual views based on experience from the perspectives of interlocking axes. That is, the views of women and men are regarded differently from the terms of pre-ordered categorisation, such as male – domination. Although, in relation to the Mental Health Officer role, gender is the axis of principal interest to my study, it is not thought of in isolation from other axes.



Initially, I had decided on the voice-centred relational method of analysis (Brown and Gilligan, 1992). This method has been adapted in various ways by different theorists, however it basically involves listening for and hearing participants' 'voices' as well as listening to the 'voice' of the researcher. The latter includes acknowledging the responses of the researcher to the participants, for instance, emotional responses. Underpinning this method is a relational ontology, that is, the self is known in relation.

I thought that the voice-centred relational method would be useful in several ways: through a process of attentively listening for and hearing participants' 'voices' and acknowledging my own responses to these as researcher, as well as hearing my 'voice' as researcher, the possibility of finding what I expect or want to is diminished; listening to accounts may produce 'richer' data, such as what overlaps with and affects gender, for example, age, class, race, economic circumstances, as people tell their stories in their own way; placing people within cultural contexts and social structures seems to be central to a project concerning gender.

I designed the pilot interview schedule and approached the pilot interviews with the theoretical principles of this voice-centred relational method in mind. Principally, the interviewer and informant are in relation. Adaptability in the interviewing technique may allow for deeper and more meaningful data to be collected. The voice of the informant needs to be heard and so statements made by the informants which are not connected to the topic in hand are given time and space to materialise. Also, there is relevance placed on 'getting to know' the individual informants as much as time will permit, such as their career backgrounds.

A 'personal experience' section of the interview resulted from considering the interview in relational terms. I as researcher relate a personal experience concerning mental health to the informants and invite them to respond in kind. This approach indicates the subjective perspective of the interviewer.



However, as a result of drawing on postmodernist and black feminist thought, I reconsidered using the voice-centred relational method. Postmodernism negates the concept of the unified self and this leads to theoretical tensions within the voice-centred relational approach of *the* self in relation.

Also, Gilligan (1988) argues that there is a 'voice' of care and a 'voice' of justice, the former identifying more as a female 'voice' and the latter identifying more as a male 'voice'. The female 'voice' is more connected and the male 'voice' more autonomous. This, however, continues a broad female-male division on a theoretical level, and my project developed away from such thinking mainly because of black feminism's influence, and also that of postmodernism. Black feminism theorises the concept of difference in terms of diversity, for instance, the differences among women and men, as well as those between women and men.

In terms of analysis, then, I have not used the voice-centred relational method. I began to do so to analyse the pilot interviews' data. The concept of gender, though, did not 'open up' from this approach to take account of the concept of difference.

## 5. POWER DIFFERENTIALS

Mauthner and Doucet (1997) maintain that it is impossible to create a research process in which the contradictions in power and consciousness are eliminated. The process is usually one of unequals, whereby the researchers hold to the power of direction throughout. Mauthner and Doucet state:

We have to accept that the entire research process is most often one of unequals and that, as researchers, we retain power and control over conceiving, designing, administering, and reporting the research. (1997, p.19).

Millen (1997) argues that part of the role of researcher is accountability for the written research product. Hammersley (1995) states that it is the responsibility of

the researcher to ensure that information provided is valid, and that this responsibility cannot be placed on to the people studied. This obligation stems from the intellectual authority which Hammersley (1995) considers to be a necessary and legitimate claim of research. However, such authority is not always accepted as part of the research process in feminism.

There are feminist methods which hold to methodological concerns, such as paying attention to the power inequities in the research relationships in order to erase them as much as possible. According to Wolf (1996), there is disagreement over who has the most power, researchers or informants. The issues of power inequities and possible exploitation are complex ones in feminist research. The danger of exploitation, Wolf (1996) argues, could be greater in situations of 'closeness' which reject hierarchy than in a more detached approach. The naming of power differentials, according to Wolf (1996), has shattered the original tenets of early feminist work which opposed hierarchy.

Similarly, rapport is regarded as a dangerous general requirement in feminist research by Reinharz (1992), since it is possible that the researcher will block out other reactions to the people studied. Rather, she suggests relations of respect, openness and clarity of communication, and these seem reasonable aims for a feminist-informed project such as this one to pursue.

Some feminist research perspectives hold to different criteria, such as a participatory ethos whereby those researched critique and change the written account of the researcher to more fully contain their interpretations. The risk of such an approach seems to be that accountability can become elusive and confused, particularly in situations of conflict between the perspective of the researcher and researched; who is accountable and when? This could place knowledge products validated by such measures in a less certain status of acceptability by the research community.

Such issues raise the question of power within research relationships and processes. This area of power differentials is an important one in feminist research, and will now be related to my own project.

My project does not hold to the rejection of hierarchy of earlier feminist work but rather accepts that the role of researcher involves some authority. When interviewing the twenty informants of my study there was the potential for various types of power conflicts and overlaps. For example, all the informants plus myself are Mental Health Officers therefore in that aspect we are on one level, however, some are Senior Social Workers or District Mental Health Officers whereas I work at times as a main grade Social Worker, and also as an independent Social Work Consultant. The fact of being a post-graduate research student at the institution of Edinburgh University also endorses academic status on my part. My position vis-a-vis the informants in professional and academic terms did sometimes result in different perspectives, for instance, more or less interest in managerial concerns, but it did not result in conflict.

Power relating to gender difference remains as an area of interest within the research process. The methodology of my study reflexively takes account of the research relationships between interviewer and informant as: female interviewer – male informants; and female interviewer – female informants.

I have found the concept of ‘critical engagement’ (Cavanagh and Lewis, 1996) helpful in relation to interviewing male informants particularly. The concept was developed by Cavanagh and Lewis (1996) when researching men who had behaved violently. They were aware of the need to engage ‘openly’ with the men but not to find themselves unable to challenge. Thus the concept of ‘critical engagement’ denotes both challenge in the term ‘critical’ and connection in the term ‘engagement’. I find this useful to apply to my own project, for example, I did not agree with some statements made by male (and also female) informants, and sometimes I could argue that or point that out to them. At other times I resolved that it was best to proceed without drawing attention to this because of, for instance, the informant’s non-verbal behaviour or tone of voice. From Cavanagh and Lewis (1996) I apply the understanding that interviewing is engagement. This engagement, though, is not necessarily inclusive of closeness but it is inclusive of critique when necessary and appropriate.

The interviews being semi-structured seems to lessen the potential for power inequalities. For instance, if the interviews had been unstructured it would have been open to informants to take them in the direction wished. This, however, leaves the possibility of the topic of interest not being concentrated on, particularly if it raises uncomfortable issues as that of gender can do in my experience. Semi-structure means that as interviewer I held the reins of 'power' to some extent, for example, determining when to leave a particular discussion to begin another. This is a responsibility which is accepted as part of the researcher role, particularly in an arena of potential power differentials.

Power inequalities are aimed to be reduced in the interviews in several ways. One way is by including a 'personal experience' statement by myself which can lead to the exposure of vulnerability. This 'personal experience' statement equalised power imbalance in the interview considerably. A second way is by mixing questions up to bring about greater adaptability and flexibility. Another way is by giving time to informant's comments and questions which keeps the interview more open than otherwise might be the case.

There is no one definition of feminist methodology. The discussions are changing within feminist research because of the influence of black feminism and postmodernism particularly. Feminist theory is undergoing a period of change and development, whereby the earlier tenets are being challenged and methodology is altering as a result. It is, therefore, an exciting and expansive time for feminist research, far from being lodged in a seventies women's movement scenario.

The method of data collection is outlined next.

### **SECTION 3**

#### **Data Collection**

##### **Interviewing**

Firstly, I will examine the theoretical bases of interviewing and, secondly, I will examine semi-structured interviewing as a data collection method.

The hermeneutic circle of being human – being an interpreter, posits that being an interpreter is a condition of being human (Schwandt, 1997). An interview in this framework is a dialogical encounter where both informant and interviewer make interpretations. In my study it is assumed that both informant and interviewer make interpretations. Silverman (1993) points out that interactionism suggests that interview responses need not be simply seen as true or false reports on reality. Instead, such responses can be regarded as displays of perspectives.

Interactionism also suggests that the social context of the interview is intrinsic to understanding any data that are obtained. Informants are viewed as experiencing subjects who actively construct their social worlds. Interviewing allows interviewers to envision the informant's experience and to hear the multiple voices in what that person is saying (Reinharz, 1992). Intersubjective depth is, thereby, sought (Silverman, 1993).

By analysing interview talk, the researcher is directly gaining access to a cultural universe and its content of moral assumptions. This position is intrinsic to Garfinkel's (1967) argument that accounts are part of the world which they describe.

The method of data collection which I have chosen for my study in relation to the methodological aims is that of semi-structured interviews. These are interviews where the interaction is sometimes directed by the interviewer and

sometimes it is not directed by the interviewer. In other words, they are constructed on both a structured and unstructured basis.

The decision of semi-structuring has, in my view, allowed for flexibility which means being able to respond within the interview to the perceived needs and wishes of informants, and it has also allowed for the schedule of questions to be followed as much as feasible. Also, questions not on the interview schedule have sometimes been asked by myself as interviewer in response to informants' statements. I sought depth in the interview by allowing space and time for informants to 'drift' into commenting on topics or issues not specifically asked about in the schedule of questions and which seem unrelated to the topic in hand. This, however, had to be balanced with the aim of asking as many of the interview schedule questions as possible, in order that gender in relation to the MHO role remained the focussed topic.

A danger to be watchful for in interviewing women and men is whether any particular difference occurs in interviewing style or substance between the group of female informants and the group of male informants. I think that the semi-structuring makes this less likely with questions to be covered as much as possible and in a limited time period, averaging one hour and twenty to thirty minutes. It is arguably more of a risk in unstructured interviewing, particularly of longer type interviews.

Most Mental Health Officers seemed to enjoy the experience of participating in the interviews and they often said so.

### **Sample**

I first applied to Fife Council to seek permission to interview 15 Mental Health Officers. They refused as they were undergoing a restructuring of their mental health teams. I then applied to the City of Edinburgh Council and after some

further explanation by telephone of what was required, such as time needed, the Council stated their interest in the project and agreed to provide access to their Mental Health Officer population.

The practicalities of managing the access were negotiated with the Research Unit of the City of Edinburgh Council Social Work Department. I wrote that I was interested in interviewing Mental Health Officers on an individual basis concerning their views of mental health social work, however these have arisen, for example, as a result of "life experience" or MHO role experience. I wrote that I was interested in interviewing Mental Health Officers of differing levels of experience, in different posts, of various ages, both male and female, of different ethnic backgrounds, and in various locations, such as hospital and area office. I explained that the interviews were expected to last around one hour and that each interview would take place at a time and location suitable to the MHO concerned. Also, I wrote that anonymity for all informants was assured, both within and out of the interview situation. I further wrote that the research results would be made available through the City of Edinburgh Council Social Work Department Research Unit, and that they were expected to add to knowledge and understanding of mental health social work.

I spoke to each individual Mental Health Officer whose name I received directly or from social work managers, and gave more detail concerning the study. Nobody at that stage then opted not to take part, and time and place was arranged to conduct each interview.

Of the 15 informants who came forward, 10 were female and 5 were male. It is worth noting that these numbers suggest possibly more interest in the project from female workers. I then requested access to 5 more male Mental Health Officers as I decided that an equal number of female and male informants should be interviewed, specifically ten of each to form a total of twenty. This further access was quickly granted by the City of Edinburgh Council, and through some of those already interviewed I had the names of 5 more male Mental Health Officers who were possibly interested in taking part. Again after telephone



contact each of these workers agreed to be interviewed and time and place was arranged.

The sample was all white, reflecting the population of Mental Health Officers at the time. The sample was based exclusively within the statutory setting because of the statutory role of Mental Health Officers. However, black workers work within the mental health field in Scotland, for instance, within district mental health associations. The sample was also somewhat limited in relation to expressed sexuality or class.

The age of most informants at interview was in the late thirties and forties (see Table 1 below), and one informant identified himself as homosexual and one as from a working class background. The age range of the sample reflects that of social work staff as a whole in Scotland. The Scottish Office Central Research Unit carried out a study between 1993 and 1997, and found that 65% of the workforce was over 40 years of age (Social Work Research Findings, no. 23).

The main focus of the study is the axis of gender relating to the Mental Health Officers' experiences. Using Collins' (1991) interlocking axes model, other axes of domination are included as much as possible, such as age, and sexual orientation. The model also importantly highlights that men as well as women can be penalised or privileged in different systems, and not purely victims or oppressors.

In my project the informants are being interviewed in terms of their role as Mental Health Officers, some of whom are in more senior departmental positions than others. There is, then, some stratification in professional terms, as outlined earlier ('Power Differentials' section). Also, four are hospital-based and the other sixteen are community-based in social work centres and a health centre. The consequences of this for the study will be looked at in the section entitled 'Hospital/Community based Mental Health Officers'.

Table 1. This table illustrates the characteristics of the Mental Health Officers I interviewed:

Informant	Title	Age	Marital Status	Children	Male / Female
1	District MHO	39	Separated / Cohabiting	Two	Male
2	District MHO	42	Married	None	Female
3	SW	36	Married	None	Female
4	SSW	40	Married	Two	Female
5	SSW	37	Married	None	Male
6	SW	45	Married	Two	Female
7	SW	41	Single	-	Female
8	Sen Prac	40	Cohabiting	One	Female
9	Asst Manager	48	Married	Two	Male
10	SW	35	Single	-	Female
11	SSW	48	Married	Two	Female
12	SSW	49	Divorced	Two	Female
13	District MHO	45	Married	One	Male
14	SSW	34	Married	None	Female
15	SSW	43	Married	Three	Male
16	SW	37	Married	Two	Male
17	SW	37	Cohabiting	One	Male
18	Sen Prac	43	Divorced	None	Male
19	SSW	45	Married	Two	Male
20	SW	34	Single	None	Male

### Ethical Aspects

Reinharz (1992) suggests relations of respect, openness and clarity of communication in feminist research and these have been adopted as reasonable aims for my study.

In order to pursue these aims, several commitments were made to the informants and to the City of Edinburgh Council Social Work Department Research Unit. Firstly, anonymity for all informants was assured, both within and out of the interview situation. Secondly, location and length of time of the interviews was agreed. Thirdly, it was agreed that a summary of the study would be sent to the Research Unit at the end of the project and, fourthly, that I would contact each informant at that time in order that they could gain access to it.

Aims to reduce power inequalities in the interviews included the 'personal experience' statement by myself as researcher and also mixing up the sequencing of questions to bring about greater adaptability and flexibility. Informants made comments and asked questions, sometimes challenging, which kept the interview more open than might otherwise have been the case.

### Practicalities of Interviews

The interviews took place in the workplaces and working time of the informants, as a matter of preference on their part. The informants were asked beforehand if they had any objections to the interviews being tape-recorded and none did. They had been assured of anonymity both within and out of the interview situation. I found that the question at the end of the interview schedule as to whether the informant has any comments to make or questions to ask often resulted in a 'freeflow' dialogue. This was a very useful way to round off the interview, and the results are considered part of the overall data.

The interviews averaged between 1 hour 20 minutes and 1 hour 30 minutes long. There was no real difference between the length of time spent in interview with male informants as opposed to female informants: average length of interview

with male Mental Health Officers – 84 minutes; average length of interview with female Mental Health Officers – 88 minutes. The interviews with male Mental Health Officers varied between 1 hour and 2 hours long. The interviews with female Mental Health Officers varied between 1 hour and 1 hour 50 minutes long. There was no difference in the length of interviews in terms of the initial interviews carried out as opposed to the later ones.

Also, as part of the method of data collection, I kept a written diary in which I put my impressions immediately after each interview of each informant, for instance, whether they appeared relaxed or tense, any changes noticed, and so on. (see Appendix 4) This stems from the concept of intersubjectivity and the interactive relation of the interviewer – informant, and aims to make the relation more explicit from the researcher's standpoint.

#### Information given to Informants Prior to Interview

The verbal outline of the study which I gave to the first eight informants was that it concerned the views of Mental Health Officers in terms of their experiences in the mental health social work role. Also, I informed them that I was interested in their views from the basis of life experience, and, if it was a male Mental health officer I was talking to I would explain that this interest included the aspect of him as a male person/male Mental health officer, and if it was a female Mental health officer I was talking to I would explain that this interest included the aspect of her as a female person/female Mental health officer. Therefore, the first few informants were told of the project's interest in gender more implicitly than explicitly, from the outline of the study given to them beforehand. Explicit questions concerning gender, however, formed a central part of each of the twenty interviews.

The reasoning at the time behind this more implicit approach to the subject of gender concerned the potential pressure which informants may feel to respond as if taking part in social work gender-training sessions. That is, the risk of receiving 'trained' as opposed to 'natural' responses. However, after carrying out 8 interviews I decided to be more explicit with each of the informants

beforehand concerning the interest of the study in gender. This change occurred, firstly, because the presumed risk did not materialise itself in informants' responses and, secondly, as a result of female informant 8 stating to me that she was surprised that so many questions concerned gender and that this had put her off her 'stride'. It is feasible that this would have occurred whether the gender topic had been explicitly or implicitly outlined, as it may have been a reaction to specific questions rather than the topic. However, the method is flexible to take account of learning in the research process, and I decided on balance that the remaining informants 9-20 should be told more explicitly that gender, in relation to the mental health social work role, was of central interest.

There was no variation in response to the gender questions by these latter informants compared to the former informants. As in the first eight interviews, some of the informants of the later interviews were more voluble, or more hesitant, than others. For example, male informant 9 reluctantly, in my view, responded to being asked if he had a preference for working with male or female service users, or no preference, by stating: '..... I don't say Oh gosh it's a woman will you, ask for a female colleague .....'.

### **Contextual Elements of the Interviews**

The social context of the interview is intrinsic to understanding any data that are obtained. This section, then, focusses on contextual elements of the interviews.

#### **Hospital / Community based Mental Health Officers**

Although the workplaces of hospital and area social work centre are quite different, the role of the MHO remains principally the same. There is overlap in that a community-based Mental Health Officer will visit service users in hospital, and also assess people for admission to hospital from the community. For a hospital-based Mental Health Officer, assessment of people for admission

to hospital from the community is also part of the role, as is visiting service users in hospital. There are some differences in practice, however, for example, community-based workers tend to carry out the majority of emergency assessments under Section 24 of the Mental Health (Scotland) Act, 1984. These assess the grounds for emergency admission to and detention in hospital.

There is usually a difference in working relationships, in that hospital-based workers are daily working alongside medical staff, including those often involved in co-working in relation to the Mental Health Officer role. This means that there is more opportunity for such Mental Health Officers to develop closer working relations with medical staff which can assist in decision-making. However, there is also the potential for social work staff to become more closely aligned with the medical perspective than those who are more distanced, such as community-based workers. The medical perspective or medical model has been presented in the chapter 'Mental Health, Gender Differences and Work Organisation'.

Informants often talked at considerable length about working relations with medical staff and this also involved gender relations. This is covered in chapter 7, in the section entitled 'Multi-disciplinary Working'. The different settings of hospital and community which the informants work in encourage the production of data capable of being analysed for contrasts and patterns.

### Being a Mental Health Officer and Researcher

As I am a Mental Health Officer and social worker, I have been an 'insider' in this sense with the group of informants. In fact, three of the informants had previously been colleagues of mine. We have often had experiences in 'common' – this came out, for example, when discussing working relationships with medical staff, in both positive and negative aspects of these relationships. There could be arguments against 'insiderness' and in this context as Mental Health Officer, these include assuming knowledge/experience in common. However, in my experience, the opposite has occurred and through dialogue in

the interview the depth of understanding between the interviewer and the informant has been increased. For example, I have been interested in pursuing the background details of statements which have included aspects in 'common' with my own understanding.

I think that it has been advantageous to carry out my own project as a Mental Health Officer for the following reasons, firstly, my study arose from the context of my previous experience as a Mental Health Officer. I thought of it because of questions concerning gender issues arising from my experience of practice as a mental health social worker. Also, experience has produced a depth of understanding that has influenced the questions I have chosen to ask and the interpretations I have made. Secondly, informants have not had to explain legal or procedural aspects of the role since I already know these, for instance, how long is allowed within the Act for the various procedures to be carried out.

### **Schedules**

This section highlights changes made to the interview schedule as well as the different ways in which the schedule was used. Firstly, changes made as a result of the pilot interviews are examined. Secondly, the different ways in which the interview schedule was used in the sample interviews are examined.

The interview schedule was used in a flexible enough manner to allow for adaptation in each interview and interviewer-informant relationship. The aim was not one of stability and neutrality since this is not a positivist, quantitative, methodology. However, the interview schedule was structured to the extent of keeping the topic of gender within the mental health social work role as the focus of each interview. My aim was to respond to each informant in terms of their individuality, and to hear their views in terms of their experiences as female and male Mental Health Officers.

### **Pilot Interviews**



I carried out pilot interviews mainly to check that the schedule of questions would prompt dialogue and discussion on the topic of interest.

Three pilot interviews were carried out with female, experienced, Mental Health Officers. Two worked within the Edinburgh area, and had both stopped practising as Mental Health Officers having moved into teaching social work practice. The other worked in the Scottish Borders, and was still practising as a Mental Health Officer. Consequently, for reasons of employment and geography respectively, these pilot informants were outwith the sample catchment population.

I did not have access to the sample Mental Health Officer population at the time of arranging the pilot interviews and relied instead on personal contacts through a study supervisor. The pilot informants were female and this is recognised as a limitation in that it would have been preferable to have included a male informant(s), given the mixed nature of the full sample. However, time constraints and practicalities resulted in this decision-making concerning the pilot interviews.

After carrying out the three pilot interviews I made some changes to the schedule of questions. These are presented next along with the MHO population' interview schedule which resulted. It was a worthwhile project to carry out the pilot interviews because these highlighted the areas which were subsequently altered.

#### *Pilot Interview Schedule (see appendix 1)*

Initially, I designed the pilot interview schedule with the theoretical principles of the voice-centred relational method of analysis (Brown and Gilligan, 1992) in mind. Underlying this method is a relational ontology whereby the self is known in relation. The interviewer and the informant are in relation. However, as stated earlier, through the influence of postmodernist and black feminist thought,

I decided against using the voice-centred relational method. I had begun to do so to analyse the pilot interviews' data but the concept of gender did not 'open up' from this approach to take account of the concept of difference.

The interview schedule used for the pilot interviews included the following sections: *introduction; biographical details; working as a Mental Health Officer; gender issues (1); life experience; service users; Mental Health Officer role; ethnic background and gender; gender issues (2); colleagues and support; understanding of mental health; closing.*

In relation to the pilot interviews I looked at which questions produced the most data. A vignette section was not, in my view, producing data of interest to the topic. The interviewees were asked to read a vignette and to answer some questions relating to it. However, responses were often related to lack of knowing details in the 'story'. This limitation resulted from trying to balance time constraints of the interviews with length of time needed to read the vignette. One interviewee, for instance, said 'It's very difficult I think...to understand really what her anxieties are about her in-laws and what exactly was the information that she felt that her new relatives didn't accept her...it's really quite difficult to say I think'

I concluded that data was not being produced as a result of the vignette and I decided it was best to ask ethnicity-related questions more directly, that is, as questions in the interview schedule. The vignette was consequently taken out of the schedule.

Also, in the pilot interviews an abstract question did not produce much data and was taken out, that is: '*Can you tell me, do you think the principal symbolic figure of madness in western culture is that of the madman, the madwoman, neither or both? (for example, in films, in art, in literature)*' It proved to be difficult for the informants to respond in any depth, and I realised that this difficulty did not occur so readily with experience-based questions. Therefore, from the pilots I concluded that focussing on experience and not abstraction would produce richer data for my project. Subsequently, there was a shift from

asking 'do you think.....?' more to asking 'in your experience.....?' and 'from your experience.....?' and so on.

Questions concerning 'ethnicity' and also concerning 'structure' were taken out. The 'ethnicity' question consisted of: *'Can you tell me what you think of the following statement – The mental health problems of white people should be looked at from the perspective of racial issues as much as the mental health problems of people of colour.'*

This was taken out of the interview schedule because of confused, even unwilling, responses. The question seemed to cause reluctant replies on the part of some of the informants. This reluctance needed consideration on my part given the goals of the research study, previously mentioned, concerning respect and open communication in the interviewer-informant relationship.

The aim had been to compare responses to this 'ethnicity' question to the similarly structured gender question: *'What do you think of the following statement- The mental health problems of men should be considered from the perspective of gender discrimination as much as the mental health problems of women'*. This question did not receive similarly confused responses from informants, and was retained in the interview schedule. However, I decided to withdraw the 'ethnicity' question on the basis of maintaining open communication.

It is of interest that such a difference occurred and may reflect the all-white pilot sample population perhaps having less confidence to discuss 'ethnicity' questions than gender questions. It is worth noting that the 'ethnicity' question came later in the interviews than the similarly structured gender question, and therefore the confusion or reluctance does not follow from the 'ethnicity' question being the first of its type. An examination of why this difference manifested itself is outwith the scope of my study but could be of interest to future research work.

A question concerning 'structure' was also withdrawn. It consisted of the following: *'In your experience, is the way social work is structured fair and reasonable, or not? Why?'* This produced data which was not mental health or gender related and so the question was taken out.

These changes were made, then, between the pilot interviews and the City of Edinburgh Council Mental Health Officer sample population interviews.

### Interview Schedule (see appendix 2)

The interview schedule covered the following areas:

*introduction; biographical details; working as a Mental Health Officer; Mental Health Officer role; gender issues(1); life experience; gender issues(2); colleagues; closing.*

Questions were asked of the informants concerning their own individual biographies. Questions were asked concerning gender differences in mental health social work, and questions were also asked concerning the informants' personal gender in mental health social work. Questions were asked concerning interpersonal relationships and mental health, and concerning risk and mental health social work. Finally, questions were asked concerning the working relations of informants with other social work colleagues and also with other professionals, such as, psychiatrists.

In the MHO population' schedule, sometimes there was not time for all questions to be asked and those usually left out were, for example: *'What took you into social work? How long have you worked as a Mental Health Officer? Have you worked in various social work locations? If so, how did you find them to work in?'* - that is, what can be termed 'getting to know the informant' questions. This could not be helped in some circumstances for practical reasons, such as time available and the relevance informants placed on different issues

requiring more or less examination. The problem of not having enough to ask never arose.

Although gender in the mental health social work role is the topic of my study, not all interview questions concerned gender directly. As stated, some time was usually given over to 'getting to know' the individual informant. The situatedness of the Mental Health Officers was considered to be of interest if time allowed, particularly in terms of its relation to their responses. As has been stated, however, all of these questions could not always be asked in each interview.

The differences which occurred in terms of numbers of informants asked the interview schedule questions resulted from individual variations between interviews and the circumstances of each interview. For example, question 18 concerning whether the Mental Health Officers enjoy working with other professionals on the whole or not, did not necessarily elicit gender-based material from informants and therefore, if time was short due to the informant's circumstances, I would sometimes drop this question in favour of other more explicitly gender-based questions. Hence, question 18 was asked of 14 out of the 20 informants.

Question 16 concerned whether service user gender is something that the Mental Health Officers routinely take account of or prefer to concentrate on when specific problems and issues arise, and question 17 concerned whether gender issues crop up often or not in Mental Health Officer work in comparison to other types of social work. Sometimes the informants' views towards topics such as those of question 16 and/or 17, had already become clear from the content of the interview carried out to that point, and so that made asking the question(s) less relevant. Therefore, these questions were dropped in such circumstances, particularly if time was short. Consequently, question 16 was asked of 9 informants and question 17 was asked of 6 informants.

Although the questions are listed in numerical order in the sample interview schedule (see appendix 2), this was not always the exact order in which

questions were asked. Again, this was dependent on the responses of informants, for example, cutting out questions changed the order in and of itself. Each interview, then, was an individual situation involving its own informant-interviewer relation.

As subjectivity is important to this feminist-informed methodology, and not the objectivity of positivist research, value-free neutrality is not sought, and so the 'stable' comparisons usually associated with positivist methods are not part of the methods used here. However, coding, categorisation and the development of themes are part of the method of data analysis, and data gathered as a result of the gender-based questions especially, will underpin these.

### Personal Experience of Interviewer

A statement by myself as interviewer was given to each informant outlining a mental health experience concerning someone close to me. I was given permission by this person for this information to be used in my research project, and anonymity was assured. It concerns the individual's experience of taking tranquilisers on a daily basis for many years, and how this situation changed (see appendix 3).

I decided to use this experience because it had had a large personal influence whereby I experienced a whole range of emotions, such as grief and anger, prior to coming to terms and reaching some understanding particularly in terms of our relationship. Furthermore, I believe that this personal experience had a part to play in my interest in pursuing this project and therefore it already had a 'place' in the study.

This personal input clearly marks the subjective approach of the researcher in this feminist-informed method and differentiates it from the neutral, detached, 'objective' approach of positivism. The personal experience statement was followed by a question asking if the informants had any personal experiences of mental health issues relating to themselves, their family, or their friends. In my experience, this subjective approach is one of the strengths of my study's

methodology as it allows for a more open and reflexive relation between the researcher and the informants.

The response from informants to my sharing of personal experience in relation to mental health matters seemed to be generally positive and, sometimes it had the effect of 'opening up' the interviews. This evidenced itself in more willing sharing of personal experience on the part of some informants and also of their perspectives towards mental health issues in the professional role. I think that this indicates a certain level of trust in that the researcher's role is not one usually associated with expressing experiences of vulnerability, and the unexpectedness of this expression produced a positive response from informants generally. As researcher, I found that it was not particularly easy to share personal experiences with twenty of my peers, especially initially, but my belief in this research method encouraged me to do so. However, as the number of interviews progressed with the consequent positive response from informants, on the whole, I found that it became much easier to share personal experience. This is a change in the interviewer-informant relations based I believe on the development of a certain level of trust or mutual respect. The latter, in my view, cannot be taken for granted, particularly when researchers expect informants to share personal experiences but not to have to respond in kind.

Also where I give my own opinion, for example, on an aspect of MHO work, this often resulted in a positive response from informants. Input on the part of the interviewer, which is not 'neutral' or 'detached', seems to generally result in more open communication, and not necessarily agreement, between the informant and the interviewer. Interviewer input which is not strictly in terms of the limited neutral 'researcher role' of positivism seems to be a catalyst towards depth of dialogue in this research study.



The method of data analysis will now be outlined.

## **SECTION 4**

### **Data Analysis**

A way of presenting the findings of this project would have been in the form of case-studies. This would have been a way of getting to know the story of each individual. However, because the locality of the sample population is a city in which the mental health services work together and individual workers are known, there would have been the risk of identification of informants by some readers. In response to this risk, I have decided instead to present the findings chapters in topic sections.

The data are organised according to a system which has been derived from the data themselves. Tesch (1990) states that this is a key characteristic of qualitative data analysis which can be considered as a commonality of the analytical process (Coffey and Atkinson, 1996).

The method of data analysis consists of various 'stages' which are not discrete or followed in a linear mode. It contains the three linked subprocesses of Huberman and Miles (1994) – data reduction, data display and conclusion drawing/verification. Data reduction includes data summaries, coding and finding themes from interview data. Data display, is defined as organising an assembly of information, that is a reduced set of data which can be displayed, for example, diagrammatically. Conclusion drawing/verification involves the researcher in interpretation, that is, drawing meaning from displayed data.

The 'stages' of this study's method of analysis are as follows:

1. Tape recordings of interviews
2. Verbatim transcripts
3. Diary
4. Table 1 – characteristics of informants
5. Summaries of topics and issues talked about by each informant; gives an overview of the content of each interview (see appendix 5)
6. Themes: coding; categorisation and conclusion drawing or verification

I have combined these ‘stages’ to make up a specific design for my project. The techniques of tape recording interviews, and verbatim transcripts, are widely used within qualitative research (‘stages’ 1 & 2). Diary-keeping has been used in different ways within the broad band of qualitative research, for example, in grounded theory strategy (Morse, 1994). In my study, as previously stated, the diary aims to make more explicit the interviewer-informant relation, from the researcher’s viewpoint. This leads to the researcher’s standpoint being more exposed, which is part of the methodology of my project. (‘stage’ 3)

Table 1 fulfils Huberman and Miles (1994) aim of data display and the importance of this, they argue, is that it aids valid analysis. (‘stage’ 4) ‘Stage’ 5, that is summaries of topics and issues, fulfils Huberman and Miles (1994) aim of data reduction, and ‘stage’ 6, that is themes, fulfils their aim of conclusion drawing / verification. These are not, as stated earlier, discrete ‘stages’. This method of data analysis, then, contains the three linked subprocesses which Huberman and Miles (1994) argue constitute data analysis: data display; data reduction; conclusion drawing / verification.

- a) Extracts from data, tagged and placed together in sets under theme headings – coding can be thought of as a range of approaches that aid the organisation, retrieval and interpretation of data. It is the ‘stuff of analysis’ (Miles and Huberman 1994, p.27). Codings link different segments or instances in the data, and are brought together to create categories of data which are defined as having some common property or element. That is, they relate to some

particular topic or theme. These concepts are related to one another. Codes, data categories and concepts are thus related to one another.

Coffey and Atkinson (1996) state that ideas for coding can come from a variety of sources that are not mutually exclusive. It can begin with a simple framework based on what the researcher is interested in, for instance, finding particular events, key words or processes in the data which capture the essence of the piece. Also, a code list can be used which is created prior to reading the data, for example, coding data according to key concepts and theoretical ideas. Each of these approaches to coding will be utilised in my study as organising principles; creating ways of beginning to read and think about the data.

Coding is usually a mixture of data reduction and data complication, and is essentially heuristic.

Coding generally is used to break up and segment the data into simpler, general categories *and* is used to expand and tease out the data, in order to formulate new questions and levels of interpretation (Coffey and Atkinson 1996, p.30).

- b) Miles and Huberman (1994) argue that coding is a process that enables the researcher to identify meaningful data and set the stage for interpreting and drawing conclusions. Once coding is achieved, the data have to be interrogated (Delamont, 1992) and systematically explored to generate meaning. Huberman and Miles (1994) have derived several tactics for generating meaning. The ones which will principally be utilised in my project are: 1) noting patterns and themes 2) seeing plausibility – making initial, intuitive sense 3) clustering – by conceptual grouping 4) counting as a familiar way to see ‘what’s there’ 5) making contrasts and comparisons – to sharpen understanding by clustering and distinguishing observations 6) shuttling back and forth between first-level data and more general categories.

Huberman and Miles (1994) point out that in qualitative research there are differences in deciding grounds of plausibility, however, there do appear to

be some *procedural* commonalities in the sequential process of analysing, concluding and confirming findings in a field study format. They regard data display as of importance in the research process since it aids valid analysis. The display should be focussed to allow viewing of a full data set in one location and systematically arranged in order that it can be interrogated. There is an interactive relation between data display and the emerging written text of the researcher's conclusions, in that each influences the other.

In my study, each interview transcript was read and re-read to establish a broad initial sense of headings and topics in the data. Questions were asked of the data, such as 'What does this Mental Health Officer have to say concerning their own gender?'. Individual transcripts were then reduced to summaries of the main points which each informant raised. Codes were then sought from the summaries and the verbatim transcripts. The summaries sometimes provided pointers and the transcripts gave the interview data in its context. I found this to be a useful and stimulating approach to coding. The next though not totally discrete stage of the process was to establish categories by broadly grouping the codes into topic areas, termed 'themes'.

This process involved going backwards and forwards between the stages, and it also involved taking account of relevant theoretical perspectives. The table, diary, and interview schedules were visited and revisited in this process as well as the summaries and transcripts.

The themes were then organised around the three levels of Collins' (1991) matrix of domination model because I found this to be a useful approach which helped to deepen understanding of the data. These levels are – a] the level of personal biography; b] the group or community level of the cultural context created by race, class, and gender; c] the systemic level of social institutions. This was a final working of the data and continued to involve the research processes of asking questions of the data, of myself as the researcher, and of the theoretical perspectives.

The themes which emerged are as follows:

1. A connection between 'male' and 'aggression' or 'violence'
2. Personal safety of the Mental Health Officer and mental health work
3. The gender identity of the Mental Health Officer and work with service users
4. Working with the medical profession
5. The difficulty men have in talking / the ease of women in doing so
6. The authority of the Mental Health Officer role, particularly concerning detention
7. Emotion and mental health work
8. Female and male workers, and abuse issues
9. Female service users who have children
10. Substituting a worker of the other sex as Mental Health Officer
11. More female than male service users
12. Age and mental health issues
13. Pressures on men
14. Sexual disinhibition making Mental Health Officer work problematic
15. Promotion in social work
16. Relationships and gender
17. Situations of potential risk / violence
18. The abuse of women as children, and mental health problems
19. Women and depression

.....

There are, therefore, different pathways into the data, or ways of displaying and thinking about the data, in this method, the crux of which appears to be

the themes 'stage'. It draws on the work of Coffey and Atkinson (1996), and Huberman and Miles (1994), and places reflexivity as an analytic guideline to fulfil feminist methodological aims. As we have seen, Huberman and Miles (1994) suggest 'tactics' for generating meaning from data. Coffey and Atkinson (1996) consider that the move from coding to interpretation involves playing with and exploring the codes and categories. This can include looking for patterns and themes, as well as contrasts and paradoxes.

The method of analysis is a dialectical process of moving between different ways of organising the data. It is, for instance, a process of moving between the data set as a whole and an individual's experiences. Not only is what is said in an interview studied but also how it is said, since the use of language transmits meaning.

The method of data analysis, therefore, needs to be, and is, reflexive, capable of analysis of views based on experience, and focussed on the use of language as the analytical medium.

A final point concerning the research process is that many of the informants asked to be informed of the study's findings. This seems to indicate some interest in the topic and/or the process of participating in the research project.

## **Summary**

This chapter initially outlined the feminist paradigm and contrasted it to that of positivism. The particular feminist-informed methodology of my study was then presented, including the methods and techniques utilised.

A feminist-informed methodological approach was chosen because of its effectiveness in researching the subject area. The methodology aims to highlight the processes relating informant perspectives, researcher perspectives, and theoretical perspectives. The exposure of the researcher's social location, and

the emphasis on reflexivity, are features of this approach. The techniques of data collection and data analysis are established within qualitative research.

I think that my study has produced data results of interest to the topic area by using this methodology.



## **CHAPTER 5**

### **PERSONAL BIOGRAPHY**

Each individual has a unique personal biography made up of concrete experiences, values, motivations, and emotions (Collins 1991, p.227).

In this chapter I draw from Collins' (1991) matrix of domination level of *personal biography*.

First, I study the individual personal biographies of some of the informants. These examples emphasise the sense of uniqueness of each individual. Thereafter, several sections are presented which study gender-related topics in terms of informants' personal biography. These topics are sexuality issues, age, emotions, and the male personal gender.

Informants consider sexuality issues in mental health social work mostly in heterosexual terms. Five informants, three male and two female, raise the subject of service users' 'sexual disinhibition' making mental health social work problematic. The issue of 'sexual disinhibition' is directly related to the personal gender and sexuality of informants and of service users.

Three male informants raise the issue of age in mental health social work and they do so in a personal sense, in direct relation to themselves and their own ages. Two female informants also raise the issue of age but neither does so in direct personal terms. Instead, they discuss age 'independently' in relation to colleagues or to service users.

Nine informants, five male and four female, raise the issue of emotion. Three informants, one male and two female, specifically mention a personal aspect of emotion when considering their work as Mental Health Officers. Each has used the personal knowledge in a helpful way in their professional role. Two other male informants raise particular difficulties that emotion can present in mental health social work, such as, too much emotional involvement leading to unbalanced judgements.

Experiences are related by some male informants which they view as indicating male power, that is, their own power as men. Other experiences are also related by male informants indicating, for example, discrimination shown to them as men.

### **Individual Personal Biographies**

In social work and social care, the subject is usually understood as an entity which is singular, distinctive and unique though not indivisible and unified within itself (Orme, 2001). The informants are regarded as unique in this sense in my study.

No two individuals occupy the same social space and so no two biographies are identical (Collins, 1991). The informants give accounts of personal biography which highlight the sense they make of their own history at the time of interview.

The personal biographies of informants include their present circumstances, such as, age, marital status and whether they have children, as well as their backgrounds prior to entering social work. Most informants had held a variety of jobs and pursued different qualifications and courses before beginning their careers in social work. Each person's background is unique including how and why he or she became a social worker.

Male informant 9 was 48 years old at the time of interview, married, with two children. He was a Merchant Navy Officer prior to entering social work. He received Home Office sponsorship to train for a career in the Merchant Navy. This informant moved in to social work because of an interest in 'social situations, sociology and psychology'.

Male informant 19 was 45 years old at the time of interview, and similarly to male informant 9, he was married with two children. Informant 19 did a variety of work prior to entering social work. He worked as a labourer on building sites, did some gardening work in Edinburgh, taught english in Germany, and worked as a nursing assistant in Gogarburn Hospital. This informant began in social work as a trainee social worker. He carried out voluntary work when younger and this developed his interest in entering social work.

Female informant 10 was 35 years old at the time of interview, and single. She did clerical work and also worked in hotels before entering social work. During this period she had over two years of unemployment and consequently she entered the Community Programme Scheme and worked at a riding school for disabled people. This instigated an interest in social work as she found she enjoyed this work.

Female informant 4 was 40 years old at the time of interview, married and with two children. This informant wanted to become an immigration officer when she left school. However, she found that she was not able to follow this career as it was not open to women at the time. Her next choice was to pursue a career in social work.

Male informant 18 was 43 at the time of interview, divorced and with no children. He had worked in the hotel business prior to moving in to social work. He states:

...there is more of an overlap between the hotel business and social work than some people would think. In the hotel business you work with a very wide range of people with various needs and demands...and that interested me, the business side of it didn't...

Male informant 15 was 43 years old at the time of interview, married and with three children. He had begun a medical degree after leaving school, and he had also travelled around playing in a band. This informant became interested in entering social work through carrying out an honours degree thesis concerning 'the attitudes of parents with an adult with a learning disability at home with them'.

Female informant 12 was 49 years old at the time of interview, divorced and with two children. After leaving school, she went to London to acting school and then worked with the BBC world service. This informant did not enjoy this work and she decided to move in to social work. She began by working as a social work assistant in the outpatient psychiatric department of a London teaching hospital.

Female informant 8 was 40 years old at the time of interview, living with her partner, and with one child. Unusually, this informant knew that she wanted to enter social work when still at school. She pursued this choice after carrying out some voluntary work and also obtaining a degree. Informant 8 was influenced by her father's career choice:

...my motivations came from the fact that my Dad was a youth and community worker and I always felt he had a very fulfilling job...that he enjoyed

Each informant's story is based on unique personal biography. The experiences, motivations and emotions are different in each individual's biography. No one person's story is the same as another person's story. For example, the way in which one person enters social work is quite different from the way another person enters social work. Also, whether an individual is married or not or has children or not, at the time of interview, reflects their own unique biography.

Another aspect of the personal biographies of informants is how and why these individuals became Mental Health Officers. Some state that the reasons for this

choice are primarily professional. Others, however, give reasons which stem from their personal biographies and these are of interest in this chapter.

Male informant 20 was brought up in a rural area of Scotland, in a small mining village. This background stimulated an interest in mental health in the following way:

...[I was] aware...as a kid...of people in the village who are a bit different from everyone else...now I can see that they were perhaps people with quite long-standing chronic mental health problems...[then] you are told by your parents not to go near them and you are always curious as to why not to go near them...

Female informant 10 also became interested in mental health as a young person. She grew up in an area of deprivation in Edinburgh. She states:

...I have had friends who have had mental health problems. Right back when I was a teenager my very best friend from school had quite a serious breakdown when we were about eighteen, and she was in hospital for about six months...it was all quite shocking and frightening at the time, it was quite difficult to understand...There was quite a big drugs culture – I come from Westerhailes – a lot of the folk I knew probably ended up with mental health problems because of their use of drugs...so it was something I suppose I was always aware of that this was a difficulty that people could have...I was quite fascinated in a morbid sort of way by mental health things when I was at school.

Female informant 2 similarly found that her interest in mental health developed because she knew people personally who experienced mental health problems.

...mental health is something that can affect us all...drawing on experience on a personal level where friends and family experienced a variety [of mental health problems]...I have been close to people with more chronic long-term severe mental health problems...

Another female informant, 4, relates her interest in mental health to her personality:

...I have always enjoyed talking to people and trying to work out what makes them tick...and there is an element of mental health that takes that further down the line...

These stories display the uniqueness of individual informants in the different ways that each became interested in mental health social work.

### **Sexuality Issues**

Sexuality is socially constructed on both the personal level of individual consciousness and interpersonal relationships, and the social structural level of social institutions (Collins, 1991). In this section, I examine the personal level of the sexuality issues of informants in mental health social work.

Only one informant stated that he was homosexual. His sexual orientation influences how he relates on a personal level to women and to other men.

I find forming friendships with women much easier than with men because...it is purely friendship, it is not about forming any sexual relationships...and I think if men know that you are gay...some of them handle it better than others and the few close male friends I have are heterosexual and know I am gay obviously and they don't have a problem with that, so it is about my friendships with other gay men which is perhaps the same thing with a heterosexual man having friendships with a heterosexual woman that it is blurred with the possibility of this being more than a friendship...

Several other informants in considering sexuality issues in mental health social work, do so in heterosexual terms only. This construction suggests that perhaps these Mental Health Officers are themselves heterosexual since if they were homosexual they presumably would not so readily ignore the homosexual possibility.



Homosexuality is not considered by female MHO 8 in the following example of service user and worker interaction.

I can think of a service user I have just now who has got a long term chronic illness who, you know, I've got a different kind of relationship because I am a female worker than I would have if I was a male, for example, it's quite a tactile relationship she wants to sort of cuddle or whatever that I would feel that maybe wasn't appropriate if it was a male service user.

From this example Mental Health Officer 8 argues that it is not acceptable for a female worker and male service user to 'cuddle' but that it is acceptable for a female worker and female service user. Sexuality is constituted in this example by this informant in heterosexual and gender-differentiated terms. The assumption of heterosexuality indicates that this informant is unaware of or discounts homosexual possibilities. Consideration of a homosexual orientation in this scenario would suggest that a female worker and female service user being tactile could be sexually problematic. The assumption of heterosexuality by MHO 8 suggests a personal heterosexual perspective.

'Sexual disinhibition' is a term used by some informants meaning behaviour by an individual which is not 'normal' but inappropriately sexual. 'Sexual disinhibition' is an issue directly related to the personal gender and sexuality of Mental Health Officers and of service users in mental health social work.

Five of the twenty informants, three male and two female, raise the subject of service user' sexual disinhibition making the work problematic. For instance, male Mental Health Officer 15 states:

The case I mentioned...it was fairly recent...but I think she [service user] had been apparently working as a prostitute and taking drugs so I think some of the body language she was using, where she chose to take me to interview her which was often into her part of the ward with curtains round and the way she you know lay back in the bed was very difficult to you know have to deal with including it made me feel very uncomfortable and well she knew it. And I think there was that aspect to things that I, you know, I think



it wouldn't have been the same had that kind of disinhibited behaviour wouldn't have been, had the same possible risk I guess to a woman. So I think that was a clear thing where I felt it didn't feel appropriate either where she had chosen to speak to me and the fact that I was a man and she was you know a woman with her recent history.

In this example, the female service user is described by male informant 15 as making him uncomfortable sexually, such as in choosing to converse with him from her bed. He also significantly mentions that she had apparently been working as a prostitute. The male Mental Health Officer sees the service user as deliberately attempting to make him uncomfortable, or that she is at least aware of the effect, since he states 'well she knew it' in this context. This statement places the responsibility for his discomfort on to the service user. Sexuality makes it difficult for him to maintain a professional relationship, and the informant regards the service user's perceived sexuality as giving her power in the relationship. In this informant's view, the personal or sexual sphere has unhealthily overlapped into the professional sphere. As a result, the service user-worker relation is negatively affected. The Mental Health Officer is unlikely to be able to effectively carry out the professional role when he is feeling such personal discomfort.

Irigaray believes that under patriarchy women's sexuality has been conceptualised in male terms, and that femininity is a role, image and value imposed on women by men's systems of representation (Russell, 1995). Male Mental Health Officer 15 regards the female service user's behaviour as sexual behaviour, and not as normal feminine behaviour in the circumstances. There is an association between female sexuality and deviancy (Ussher, 1991). Informant 15's view suggests stereotyping since a woman who is thought to be a prostitute is regarded in sexualised terms. Her behaviour is perceived sexually because of values attached to it in relation to the description 'prostitute'. As such, this suggests that it may be a discriminatory perspective. De Beauvoir argued that the prostitute has been denied 'the rights of a person' (1988, p.569).

Further, informant 15 dismisses the possibility of a homosexual perspective when he states that the female service user's disinhibited behaviour would not hold a sexualised risk to a female Mental Health Officer. Rich (1987) has argued that compulsory heterosexuality erases homosexuality. Male MHO 9 also expresses a view based on heterosexuality:

I mean I suppose any male would naturally get quite distressed when a young woman is displaying disinhibited sexualised behaviour. It can be quite embarrassing and I am very sensitive to that. I find it is a fairly frequent presentation which I have come across on a number of occasions and I suppose that is I don't know if that is an ideal but, you know, tried to act appropriately

As with informant 15, Mental Health Officer 9 constructs these service user-worker relations in terms of a gender-based heterosexual problem. He states that disinhibited sexual behaviour is a frequent presentation by female service users. In using the term 'presentation', this informant is relating the behaviour to the mental health problems of the service users. Also, since he works in an emergency social work team, he is probably dealing with situations of crisis on a regular basis. This male Mental Health Officer is also made personally uncomfortable by such behaviour, stating that it can be embarrassing and that he is sensitive to it.

Male informant 13 states:

I am working with a female who I sectioned this morning who I have known for a number of years, lovely lovely person, she was totally sexually inappropriate and I must I mean I do find that quite difficult. I phoned yesterday and I got this twenty minute explicit account and it's not appropriate, I don't know what it was about, shocking people but then even today I was talking to her about sectioning.....then she became like suddenly she was there and I am going just a minute. It does get very difficult that because she had lost all sense of boundaries, personal space, and that sort of thing and I think that is quite difficult because you are having to say I want to work with you and help you but not this kind of rejection bit that people don't particularly understand in a psychotic having a psychotic episode and it was all illness driven and that wouldn't have happened with a female.....she wouldn't have come on to a female worker

but we have to manage this, we haven't got the luxury of bringing in a woman... so yes I have had problems with sexual disinhibitions or whatever as a feature often a feature of mental illness.

This informant gives an example of working with a female service user whose behaviour is disinhibited, such as losing her sense of personal boundaries. This is a service user he has known for several years and so he is able to see the difference between this sexualised behaviour and her behaviour otherwise. There is an emotional dimension in that he finds the change which disinhibition brings difficult for her as well as for him. The relation becomes strained from his perspective because of the conflict between maintaining professional distance and maintaining the connection of the service user-worker relation. As with the previous two male informants, this Mental Health Officer finds sexual disinhibition on the part of a female service user difficult to work with. Also, he has experienced this difficulty often in mental health work. Similarly, to Mental Health Officer 15, this informant apparently dismisses the possibility of a homosexual perspective in that he states that the disinhibited behaviour would not occur if the relation were female service user – female worker.

Phillips (2001) argues that women service users are vulnerable from male mental health social workers. Male workers will be offering counselling and support to women, and men, who are overwhelmed at times by chronic mental disorders, and who are therefore vulnerable to 'predatory professionals' (Phillips 2001, p.144). Certainly, the experiences of these male informants show periods of female service user vulnerability in their professional working relationships. However, this is experienced personally by the male Mental Health Officers as making them uncomfortable or vulnerable also. Phillips (2001) recommends that men social workers in mental health should adhere to an ethical prescription which covers all aspects of their personal and professional conduct.

Female informant 8 states:

I think it [being a female MHO] sometimes is a disadvantage with people that are disinhibited, sexually disinhibited, and they will see you first of all as a female, a woman, whatever and may sort of interact with you on that level which could be entirely sort of inappropriate in your position, you know, as assessing them for potential compulsory detention and sort of in the aftermath of that it may be no different to social work in general, you know, people can be inappropriate and disinhibited and sometimes the fact that you are female means that they react to you in a particular way.....I suppose I am talking mostly about male service users I mean I have been in that position where people have acted in a sexually inappropriate...they are sexually disinhibited, and I have just sort of reacted accordingly to those situations, so I suppose it is a disadvantage being you know female in that situation, well it wouldn't be an issue I think if it was a male worker.

This Mental Health Officer is the only female informant who talks of directly working with male sexually disinhibited service users. Other informants, both female and male, have elsewhere considered situations of male service users who are being abusive, sexually or physically, towards female workers, for instance, in terms of substitution of the latter by male workers. However, female Mental Health Officer 8 relates experiences of working with male sexually disinhibited service users and of reacting accordingly. She does not talk of substitution as a solution. This informant does not consider in her statement any risk element of such situations. It seems, then, that she attempts to manage these situations of working with male sexually disinhibited service users on her own terms. There are wider implications, however, such as organisational responsibility. The issue of organisational responsibility will be discussed further in the 'Practice Issues and Policy Implications' chapter in relation to the personal safety of workers.

Also, this female Mental Health Officer regards sexual disinhibition in a heterosexual framework between herself as worker and male service users. She states that the sexually disinhibited behaviour of male service users would not occur if the situation involved a male worker instead. The construction of these experiences by this informant in heterosexual terms again erases the homosexual possibility.

The domination of heterosexuality is assumed, then, by this female informant and several male informants. This assumption presumably relates to personal biography in that if any of these Mental Health Officers were themselves homosexual they would not be closed off to, or discount, the homosexual orientation. Personal biography in terms of sexuality, then, may influence working relationships between service users and workers. For instance, a Mental Health Officer who tends to discount the homosexual orientation may not perceive very readily the needs of homosexual service users.

### Age

Age is part of the personal biography of informants. Collins (1991) states that each person occupies their own social space, and that two individuals do not occupy the same social space. Cree (2000) argues that individual experience is structured by class, race, gender, age, disability and sexuality. In this section, the emphasis is on what age means in personal terms to the informants.

Several informants talk about age, often in relation to gender, in mental health social work. Sometimes this is in terms of their own age and the effect that has on their work with service users, and it is usually related to whether the service users are the same or the other gender to that of the informant.

In considering the topic of gender differences in mental health social work, three male informants, 9, 15, and 18, have raised the issue of age and in a personal sense, in direct relation to themselves. Of the female informants who raised the topic of age, 8 and 12, neither did so in personal terms but 'independently' in relation to colleagues or to service users. Also, of the male Mental Health Officers, two relate age to mental health social work in conjunction directly with gender and the other does so indirectly.

Male informant 9 states in relation to age in working relations:

There may have been occasions where I have just been able to engage more naturally because it's another male maybe of a similar age and I have felt quite comfortable with that.

In working with a service user, this Mental Health Officer feels more comfortable in terms of having common ground regarding gender and age in that the service user is male and of a similar age. Therefore, age does not stand alone but in conjunction with gender in his perspective. The personal biography of the Mental Health Officer helps to create a 'comfortable' working relation between him and the service user. He states that he feels 'quite comfortable', suggesting that communication will be reasonably open and not forced in such a relation.

The statement by Mental Health Officer 9 that he is able to engage 'more naturally' with another man of similar age raises the question of how he would find engaging with, for instance, a woman of different age to him. Difference, in terms of gender and age, is outwith the construction of what for him is 'comfortable' in a working relation.

Male informant 13 gives a different view of age in relation to male gender. He states:

...males tend to kill themselves more....sadly it's middle aged, overweight men so I've got sympathy there, smoke and drink too much, you know, so I mean it's yes obviously I would think I have sort of that male perspective and potential risk.

This relates to female informant 12's view concerning whether Mental Health Officers see gender as a relevant issue in the MHO role:

...it will be interesting to see whether that has got to do with...when I say age I mean more where they are in their lives...



This Mental Health Officer is suggesting that the perspectives of informants towards gender and mental health social work may be connected to the individual informant's life-stage or age. This possibility places a link between the age, or life-stage, of the individual informant and his/her perspective on gender in mental health social work. This Mental Health Officer is placing a connection between the personal biography and the professional role, though not in direct relation to herself. Her view also suggests that gender perspective does not stand alone but in relation to other factors, such as age. Male Mental Health Officer 13's view is one of some negativity concerning how age, specifically middle age, interlocks with male gender and he relates this to himself personally. Middle age is his life-stage and this is of importance to his view of age, gender and mental health:

...male inability to support family can kick off often you see the downward spiral if you are looking at male middle-aged male depression, middle age that is a crisis time we are told for men, haven't had one yet the alleged middle-aged crisis menopause whatever you call it but it is a time for a lot of men of saying 'well here it is you know it's all behind me now, what is the future?' and in this day and age there are employment issues about that, the feeling they haven't achieved or being extremely frightened about the future, there is redundancy, often go hand in hand with an increase in drinking and other things, loss of interest in sex, family leaving home. Your purpose is finished, they are off you are left now with probably a partner that you haven't really engaged with for the last twenty years because you were bringing up your family and whatever. And I think those sorts of things can impact a great deal on men's mental health, similarly to females but possibly in a different way, probably in the sense that they are trying to make sense of why maybe a partner is fading away and not taking an interest...I suppose from the female's perspective again it's about, you know, your family you've done your job if you like, your family are on their way, then settling down to thinking 'well now it's my time' and you look round and, you know, suddenly his only interest is in the football, the telly and you think 'what is it all about?', and I suppose you get that time...and sort of reappraising relationships, reflection, hope for the future, worry, often it's a time when people are suffering not only losses of their family moving on but parents and this sort of thing so I think that crucial middle age time does impact on male and female, and I think the outcome is the same.

The view of this Mental Health Officer is that age, in terms of life stages and expectations fulfilled or not, is related to mental health. He details middle age for



both a man and a woman though mostly negatively, for instance, hopes not met and issues of loss. These include redundancy and loss of interest in sex in relation to the man, and bringing up children and the relationship with her partner in relation to the woman. This informant's perspective incorporates both gender and age as relating to the mental health of service users, and in terms of social roles. What he presents is a very traditional view of men and women, with men as breadwinners and women as childrears.

Male informant 18 also associates gender and age in the service user-worker relationship with roles, though in a different sense:

RM: I really just wonder because you have mentioned it a couple of times just you said about when you review your service user caseload you looked at gender and age then you mentioned the elderly there in relation to the gender question and I just wondered what you are thinking at the back of that, you know, you are sort of putting gender and age has popped up.

MHO: Well I think it is about roles that one gets into as a social worker or MHO, and I would need to look at myself and one of your first questions was 'what age am I?' and as a forty three year old if I take now a likely role, I mean I am not a parent myself, but a likely role that a forty three year old male might take on with say working with a young man or a young woman maybe in their late teens, in fact who I am going to see after this, is almost like searching for a substitute Dad figure.

In response to being asked what he considers the relevance of age to be, Mental Health Officer 18 replies in terms of the roles that a worker and service user may adopt. For example, he states that when working with a young woman or man he may be regarded by them as a type of father figure, and that is a probable role for him, or a male worker of similar age, to take on. Professional and personal aspects, therefore, are to be found within such a relationship, for instance, the service user might respond to both aspects in relation to the worker, and the worker in relation to the service user. However, there are risks attached to such roles, such as the possibility of emotional over-involvement on the part of either the service user, the Mental Health Officer or both.

Again, as with male informant 9, this Mental Health Officer relates his own age as well as personal gender directly to the service user-worker situation, in terms of these making a difference in the construction of the relation.

Male informant 15 states concerning age and gender in mental health social work:

I think it is often, you know, the age that is somehow more of a factor [than gender], I mean I think it often depends if someone perceives you as someone of a similar age or younger that seems to be expected as I get older but I think working with people much younger is more of a challenge I suppose than working with people whether they are men or women because there is that big difference that an understanding of how many women in their twenties think or what they do now because I have no direct experience of that at all either myself or with kids.

This Mental Health Officer also considers age as making a difference in working relations, and more so than gender. However, the example he gives is an across-gender one concerning younger female service users and the difficulty that poses to him in terms of reaching understanding of their perspectives. Male informant 15 relates this difficulty to lack of 'direct experience' which appears to mean that he does not know younger women personally or has not worked with younger women.

Female Mental Health Officer 8 does not consider age in a personal sense but in relation to working with service users, and specifically regarding assessment for detention:

I mean, you are sort of looking at every individual's circumstances and I suppose, I suppose, most of my experience has been, you know, people have had long-term chronic sort of mental illnesses. I sort of think of it really in terms of age and life stages rather than gender that, you know, people in my experience do really have their first episode of a serious psychotic mental illness when they are quite young so in a sense it's to do then whether they are male or female about sort of life chances and how it's going to affect them.

This informant considers that people develop psychotic mental health problems in terms of age rather than gender. In stating 'life chances' in this context, Mental Health Officer 8 is suggesting not gender-related differences but, for instance, differences in availability of resources, employment prospects and so on. Therefore, gender is not a major issue here according to this Mental Health Officer whereas age is of relevance.

It could be that the male Mental Health Officers have personal experience of changing their perspectives on age as they become older. Each of them is over 40 years old. This may be an area of possible discrimination that they can relate to more than gender, particularly since gender discrimination in social work and mental health training is usually focussed on the 'female'. The female informants, on the other hand, may be able to relate to gender discrimination more personally and so raising age as an issue is not so obvious to them in this context. This is despite the fact that they are similar ages to the male informants, that is, 40 and 49 years old.

Age discrimination usually refers to the experience of older persons, and more particularly to the experience of older women (Kramarae and Treichler, 1992). Such discrimination, then, is also part of the experience of older men. Therefore, it may be said that although men are privileged in gender terms, as older men they are penalised in terms of age. This could explain the focus of the men on age in personal terms, since associated discrimination or penalty is something that they may have had experience of as they have got older.

### **Emotions**

Emotions are part of the unique personal biography of each individual, according to Collins (1991). For instance, an individual's emotional responses and emotional

history are unique. No one individual has had exactly the same emotional experiences as another because no two individuals occupy the same social space.

Several of the informants talk about the expression of feelings within their own personal experience or within the context of mental health social work. Sometimes the informants speak of emotional expression as an overlap between the personal and professional areas. Gender is often of relevance in understanding what is being said, and at times is brought in directly by the informants themselves.

Of the 20 informants, 9 raise the issue of emotion and these consist of 5 male and 4 female informants.

Male informant 5 states:

...the gripping eye I am part of, grew up with, is not all that keen on men crying, expressing emotions of affection or love openly and that can be very very difficult, I can personally find that very very difficult, and you can imagine you can easily envisage that somebody's mental health difficulties can spring from exactly that kind of pressure of not conforming, not being what men are supposed to be although we all have an idea of what men are supposed to be sort of, although I am not sure what that is...

The informant states that pressures which arise from an individual not 'conforming' can lead to mental health problems. His perspective rests on an assumption of the individual not fulfilling gender 'norms' and this lack leading to some mental health difficulties. These 'norms' are associated with social pressures to conform in behaviour. This creates the conditions for possible mental health problems when conformity does not arise. He states that he personally finds such pressures difficult. MHO 5 gives an insightful view of men's emotions, including his own, in relation to social pressures.

Mental Health Officer 5 suggests that men appear not as emotional as women because men are holding back signs of feeling. From this perspective, it is possible

for men to be as emotional as women but 'the gripping eye' places limits on what is socially acceptable. The words 'the gripping eye I am part of' suggest a gaze which is social in origin. He states that emotional display is not valued from men and he then relates that to mental health.

Lupton (1998) argues that men have typically been considered as 'blunter' in their emotional styles than women. Phillips (2001) considers that men are more emotionally restrictive than women, and that the emotions men more readily express are potentially destructive, such as anger and aggression.

These perspectives of men as 'blunter' emotionally than women, and of men as more emotionally restrictive than women, are suggested in Mental Health Officer 5's understanding of emotional experience in personal terms. He also relates his experience to the behaviour of men as a whole group.

Emotion or emotionality themselves at a general level of meaning tend to be culturally coded as feminine, while rationality or lack of emotionality are dominantly represented as masculine (Lupton 1998, p.106).

Informant 5's view is that, from his own experience, the masculine representation of 'lack of emotionality' (Lupton, 1998, p. 106) and specifically that associated with caring, results in behavioural expectations which if not adhered to could lead to mental health problems.

It seems apparent that the whole categorisation of 'masculine' and 'lack of emotionality' is gendered and highly value-laden. Mental Health Officer 5 points out that in general terms the man who openly cries is behaving in a manner which is not as socially acceptable as the man who does not cry. This is a gender categorisation that I also recognise from my knowledge of social behaviour patterns. From his perspective based on the personal experience of being male, informant 5 has found difficulty applying the categorisation to his own feelings and behaviour.

A struggle is suggested between the social meaning and the personal meaning. This can be looked at in Schutzian terms. In this case, the informant's perspective is understood in terms of the typification applying meaning to experience in social terms, but this meaning is not one that he finds acceptable as an individual. This, however, does not mean that he does not attempt to understand himself in terms of the categorisation, at least sometimes. There seems to be a struggle involved for informant 5 between rejecting the categorisation as applying meaning to his personal behaviour, and accepting its terms because of social acceptability. It is this struggle which leads to him experiencing difficulties in relation to the typification. The struggle also indicates the fracture between categorisation and experience, which Mental Health Officer 5 is very much aware of. Typification, then, applies meaning to experience from such a perspective, and also through the process of self-reflexivity can result in an awareness and, at least partial, rejection of that categorisation. In other words, male informant 5 associates 'masculine' with 'lack of emotionality' but in personal terms finds it difficult to be unemotional sometimes. This personal experience causes him to question the categorisation.

Male Mental Health Officer 19 has held a typified view of connecting 'women' with 'emotion' in the past but he states that that is no longer the case:

...the absence of relationships or the poverty or superficiality of relationships that people have I would say is a greater thing towards that and affecting men and women. Now I would say that seems to be much more so in single people in the main the, sort of, like the types of the family relationship or how much you are affected by your situation or your marriage or whatever, there are more difficult areas of that, you know. I think it is much more mixed up now, I think at one time I would have thought yes women are more damaged in this area I don't I wouldn't say that now.

This informant talks of the depth of relationships: 'how much you are affected by your situation'. He previously considered superficiality of relationships to impact more negatively on women than men but no longer holds to this view. His original view suggests Lupton's (1998) cultural coding of emotionality as feminine and lack



of emotionality as masculine. The change may be explained in relation to cultural change. Recently the categorisation in social terms has been modified through the influence of the media in that emotional depth is discussed more in terms of men's lives than in the past. The media presents a crisis in terms of defining masculinity. For instance, men are less sure of what is socially expected of them within families and within society generally. This is raised as an issue by male Mental Health Officer 5 above where he states:

...we all have an idea of what men are supposed to be sort of, although I am not sure what that is...

This lack of certainty can lead to social and emotional confusion. The link of 'emotion' to 'men' seems less certain and more complex, in these informants' views, than the link of 'emotion' to 'women'.

Female informant 8 links emotion, often strong emotion, to mental health problems:

Sometimes because the situations are so extreme people's emotions are so sort of overwrought, you know, people are upset basically.....I mean, you go through life you have got sort of personal traumas in your own life, I mean, I haven't actually experienced a sort of mental illness in the sense that you know I received treatment or whatever but obviously I have gone through traumas in my life with hindsight probably but I think at the time as well, you know, being aware of my own emotional reaction to the fragility of your mental health at times, and that has been an important factor in how I see other people and see how they are dealing with trauma.

The perspective of this informant is based on her experiences as a Mental Health Officer. These experiences are related to her personal experiences of life traumas. Strong, even extreme, emotion is linked by this informant to the mental health problems of individuals but not in a gender-specific way. Mental Health Officer 8 uses the term 'people' which indicates that she sees emotion associated with the mental health problems of both women and men.



Male Mental Health Officer 5 links emotion to the mental health problems which his father experienced:

My father was a prisoner of war with the Japanese ....he retired about 50 because of psychiatric problems .....and he dealt with a lot of his problems by drinking far too much and getting angry and shortened his life, and as a result of that I don't know why I think that kind of puts me in touch with people's sense of helplessness sometimes but not in a good way, not in a way that kind of makes me feel you know well that's OK now things are different I can do that with somebody or I can help facilitate that happening for somebody. And there is a lot of helplessness there and even as I am talking about it just now I felt myself plugging into that, but what I am saying is that that experience I think makes me realise how difficult life can be for people in terms of their mental health and also how that can sometimes just not be reached and not be anything you can help anyone with and the best that you are about is trying to make sure they don't damage themselves or others within excessive limits.

The emotion identified by this informant as experienced by his father is anger, and an associated helplessness. Generally, Mental Health Officer 5 identifies a sense of helplessness, and a problematic area which cannot be reached by others, in people with mental health difficulties. This suggests an emotional state which is not just extreme but beyond the grasp of people who are considered not to have such problems. Such 'outside' experience presumably gives knowledge which others do not have.

Again, as with Mental Health Officer 8, this informant uses the term 'people' and is not linking emotion to mental health problems in a gender-specific way. That is, emotion is linked to the mental health problems of both women and men through lack of specificity. Another possibility is that the informants are using the term 'people' when meaning 'men'. In either case, emotion is linked strongly with men and this is in variance to the cultural link of emotion with women. However, the emotions which are mentioned tend to be those associated with male 'emotional restriction' (Thompson, 1995), such as, anger.

Female Mental Health Officer 7 relates mental health problems to issues of abuse including emotional abuse. She states:

When you look at somebody with a mental health problem and he has got issues of abuse in present and past lives, and I've often seen emotional abuse going on in relationships, emotional abuse doesn't and it is interesting that you use the word 'relationships' as opposed to 'partnerships' which is important because often the emotional abuse can be from Mum to daughter or daughter to mother, as with any partnership so I have obviously met many...interesting I haven't met many men and I wonder what that is about as well...but I mean I have worked with a couple of women on the ward who are physically abused and emotionally abused by their partners and I have also seen emotional abuse from family members.

Emotion, as abusive emotion, is related to mental health difficulties by this informant, though not in a gender-specific way. She mentions that she has not met many men in the context of working with people who have suffered emotional abuse, or who have possibly been emotionally abusive. For such a recognition to be made, however, indicates that gender-differentiation is occurring in terms of the comparative numbers of men and women which this Mental Health Officer has worked with regarding emotional abuse.

Female informant 12 states:

I don't find it difficult to discuss painful issues with service users because I do it myself in my own life.

This MHO links the emotion of 'painful issues' experienced by service users to her own personal experiences. This Mental Health Officer relates the personal experience of discussing emotional issues to her professional working role. The personal and professional overlap because of linked knowledge through emotional experience.

Three of the informants specifically mention a personal aspect of emotion when considering their work as Mental Health Officers. These three consist of two female

informants, 8 and 12, and one male informant, 5. Each has used the personal knowledge in a helpful way in their professional role. Female Mental Health Officer 8 states that an awareness of the fragility of her own mental health at times has helped her to perceive and understand others who are experiencing mental health difficulties. Female Mental Health Officer 12 links her ability to discuss personal emotion to her work with service users, as stated. Male Mental Health Officer 5 struggles personally with social conformity in relation to emotion and he considers that this helps in understanding how some people's mental health problems arise.

From their experience, however, two of the male informants, 18 and 15, raise particular difficulties that emotion can present in mental health work. Firstly, male Mental Health Officer 18 states:

...roles that one might take on, I might take on a sort of father type paternal role with a young woman or man of that age, with somebody of my own age you know if I was heterosexual I might seek somebody of my own age as a possible sort of partner role or if I was homosexual I might seek a man as a partner, you know, that might be the sort of hidden agenda, and with an elderly person I might be looking for a parental figure or relate to that as a son to a mother or son to a father so I am kind of aware of that. These would be the sort of traps I think that you could get into as a worker...are you putting out the vibes that you want to be a Dad, you want to be a partner or you want to be a son to somebody, you see what I mean to simplify it all out, or friend, or yes I am aware of age and gender in terms of how I might relate to that person that was sort of unprofessional just as they might relate to me. I think we are talking about transference as well and counter-transference and I can get into it and I think a service user could get into it as well and not all of it is unhealthy because there is a measure of transference in all relationships.

This informant, in talking of transference and counter-transference, is meaning the emotional attachment from other types of relationships is transferred to the worker-service user relationship, and by either of the participants. For instance, the attachment of father to son is inappropriate to the relation of service user and worker. However, this Mental Health Officer is aware of the risks involved in such

transference but he also regards it as possibly being able to add some positive element to the relation. As with female informants 8 and 12, and male informant 5, this suggests that the positive aspect could be the use of personal emotion as a source of identification and knowledge. The danger with any identification is that it can become inappropriate, for example, over-identification, or sexualised identification. As stated, male Mental Health Officer 18 is aware of any such risk and alert to the overlap of the personal and the professional spheres.

It is worth noting, also, that this informant does not state his view in heterosexual terms only but is aware of the homosexual, as well as heterosexual, orientation.

Secondly, male Mental Health Officer 15 states concerning difficulties that emotion can present in mental health work:

I think it is useful to have a Mental Health Officer involved in sections and take the weight off, any pressure on, family to make these kind of judgements or decisions which really aren't informed or emotionally loaded .....but I think from a professional point of view you can take a different stance from that I think it is when you get too close I suppose that is like when we were talking about sections and families being involved or people close then it is far too close because you can't recognise it, and you can't admit it that you know somebody is not well particularly in that, you know, you can't see the marks but clearly somebody is unwell and I think that is why I would stand up and say it needs a Mental Health Officer in these kind of circumstances because you know we take a wider view of things.

This male informant regards the professionalism of the Mental Health Officer role as useful when making decisions because emotion is kept in check. He thinks that families of service users, that is those close to the latter, may make unbalanced judgements because of the influence of emotion. The suggestion here is one of the need for a degree of objectivity and a limit on subjective involvement which is displayed in the term 'emotionally loaded'. Male Mental Health Officer 15 considers that too much emotional involvement leads to unbalanced judgements.

Hearn (1987) argues that for men 'being professional' may mean not showing certain emotions, especially in the control of others' emotions. This is reflected in the view of male informant 15.

Emotion, in MHO 15's view, is not seen as a positive source of knowledge but as an element of a situation which needs to be kept restricted. This is a contrasting view to that of female informants 8 and 12, and that of male informant 5. These three Mental Health Officers, as outlined earlier, use their own emotions as sources of knowledge which they draw on in relation to mental health work. Emotion for them is a source of identification with service users at times, and so it is a positive part of the Mental Health Officer role in their perspectives. The different views of these three MHOs and MHO 15 indicate different types of practice, in that informants 8, 12 and 5 use their personal emotional responses to provide insight into their work as Mental Health Officers, whereas male informant 15 is of the view that a lack of emotional involvement is one of the strengths which a professional worker has. It could be argued that the view of MHO 15 is a form of controlling emotion, including that of others. This could lead to him not being as likely to take as much account of the views of service users' families since he regards them as generally emotionally (mis)led.

### **The Male Personal Gender**

In this section, I examine what male informants have to say concerning their personal gender, and particularly male power from the personal perspective.

Rossiter (2000) argues that postmodern feminism suggests that to consider anything as outside of power is itself a ruse of authority. Gender relations, from this view, are power relations.

Two of the male informants relate experiences they view as indicating male power, that is, their own power as men. Firstly, Mental Health Officer 18 states that he has

more power or sway over female service users than does a female colleague simply because of his male gender. He believes that female service users do not disagree with him as much as they may do with a female Mental Health Officer. He connects this power which he experiences personally to the societal power of the male gender group.

Secondly, male Mental Health Officer 19 speaks of working with a particular female service user whom he believes he has influenced towards complying with social work input because he is male. He talks of this as a gender struggle: 'it helps being a man here threatening a woman'. This statement describes the male power of Mental Health Officer 19 in terms of a threat to this female service user. This male ability to intimidate would appear to be how he himself views such power, that is, in specific gender terms. The working relation of the Mental Health Officer and the service user is a power relation which aligns more power with the Mental Health Officer. In the informant's statement, the power is associated not simply to the working relation of Mental Health Officer and service user, however, but to who is a woman and who is a man. Gender difference is implicit in this informant's statement and the meaning concerns the female service user being persuaded or 'threatened' into compliance.

This is a concerning aspect of gender relations. It is not merely the authority of the role being enacted but it is the use of personal male gender and its presumed associated power. Various informants, both female and male, speak about personal gender as being helpful at times in Mental Health Officer work but sometimes a hindrance. In the instance given by MHO 19, however, personal gender is actively drawn on as a resource to threaten in order to influence.

This influence is similar to that described by male Mental Health Officer 5 when he decides to dominate a team meeting of female colleagues. He states that he can dominate a team meeting should he so choose because his colleagues are female and he is male.

There are assumptions behind the statements of the informants. For instance, the female service user in male Mental Health Officer 19's example may also have complied with a female Mental Health Officer. Also, the female colleagues of male Mental Health Officer 5 may have allowed another female worker to dominate the team meeting and denied informant 5 his assumed ability to dominate. The perspectives of the male MHOs are interesting, not because they can be ascertained as 'accurate' interpretations but because they stand as the interpretations of these male informants. Male Mental Health Officer 5 and male Mental Health Officer 19 assume that their gender is the reason they have power in these situations and it is this assumption which is significant - masculinity is constructed interactively by them and in terms of them having power to dominate women.

However, this perspective of power being associated with the male gender is not necessarily consistently held to by male informants. Mental Health Officer 18 talks of being discriminated against by his colleagues because he is a man. He does not elaborate on how this discrimination shows itself. However, he states:

I don't tend to talk about that too much...

This is an interesting comment in that it reveals that this informant does not wish to, and mostly chooses not to, talk about discrimination which he has experienced. He also assumes that men exert power in society, and have done so for centuries, and perhaps finds it difficult to talk of instances when this is different for him personally. Perhaps, for example, when he is feeling powerless or somehow mistreated.

Also, another male Mental Health Officer, 5, states that as a white, heterosexual man he has power within society but that he does not always *know* that this is the case:



...I've got all this power then how come everything feels like such hard work...

It is interesting to note that this is the same informant who considers that he can dominate a team meeting of female colleagues. He also states regarding a female service user:

...who has had a desperately awful time with men, and you know the kind of time when it makes you despair of your gender...

This informant's comment is based not on male gender unity but rather it highlights differentiation as he distances himself from the male gender group by use of the term 'your' in relation to his own gender group. Also, he distances himself from the male gender in his statement of 'despair' regarding his own gender. Informant 5 is indicating differences between the group 'men' relating to what constitutes acceptable behaviour by highlighting his own position.

Male MHO 5's different experiences reveal contradiction within the gender experiences and understandings of an individual. As Harding (1987) argues, gender experiences are often in conflict in any one individual's experience.

In the feminist theory of the 1970s, power between the gender groups tended to be conceptualised in patriarchal terms. Various forms of male power have been implemented in archaic and contemporary societies, such as the power of men to deny women sexuality (Rich, 1987). More recently, due to postmodernist theorising particularly, there has been a growing recognition of the complexity of power relations in which women and men find themselves embroiled. Women are in differing power positions in relation to other women, to men and to children (Featherstone, 1997). In terms of power, gender relations are forms of domination but ones with no fixed pattern (Featherstone and Trinder, 1997).

Collins (1991) regards power as oppressive and productive. She argues that traditional accounts of power assume that domination operates from the top down, creating a system of victims and superiors. However, according to Collins (1991), this assumption does not recognise the power of self-definition and the importance of consciousness which are significant within personal biography. No two biographies are identical, she argues, and human ties can be freeing and empowering, or confining and oppressive.

Male Mental Health Officers 18 and 19 have constructed gender relations in examples given above in terms of power as a form of domination. These MHOs have a belief in a male power created and re-created in the interactions with female service users. However, Mental Health Officer 18 states that he has also experienced discrimination from colleagues because he is male. These examples of informant 18 highlight the importance of consciousness and self-definition, and how these can change.

In the examples given by male informants there are different constructions of masculinity or what it is to be a man. Lupton (1998) focusses on the performative nature of femininity and masculinity by arguing that the project for any individual of taking up different femininities and masculinities varies over her/his life course, and even within the context of a single day. Similarly, Kimmel (2000) places variation as integral to the social construction of gender relations by, for example, arguing that gender definitions vary over the course of a person's life. There is variation, for instance, in the views of Mental Health Officer 18 in that being a man is constructed in terms of having power and also of being discriminated against. The former relates to the gender group and categorisation 'men', whereas the latter stems from experiences he has had as an individual man. There is a fracture between categorisation and experience, and this shows variation in the views of this informant.

While the axis of gender may privilege men, in terms of personal biography each individual is unique and interprets situations 'in his own way'. Taking this approach, an individual male informant's view can be understood more fully when related to personal biography as well as to axes of domination – not simply either/or, such as, either oppressor or oppressed. This approach captures the complexity of gender relations as interactive and interpretive, and the gender experiences of any individual male as complex.

In this chapter, I have examined the individual biographies of some informants which emphasise the sense of personal uniqueness. Also, I have studied several topics which relate to gender from the personal perspective.

Variation is found in individual informants' personal biographies, for example, in age, sexuality, and emotional issues. Several informants raise the topic of age and a difference has been found between female and male informants' views. Though there was no difference in the age range of the female and male informants who speak on the topic of age, it was only male Mental Health Officers who related age directly to themselves in their working relations as something that matters. Age discrimination, therefore, is focussed on as something which men can have experience of as they get older and which is different to male gender privilege.

Sexuality issues are strongly constructed by some informants in heterosexual terms. A personal heterosexual orientation is suggested by these informants' statements.

Two female informants and one male informant have found personal emotional issues to be helpful in the professional role. Their views are that the personal experiences of emotion have been helpful in terms of understanding, and communicating with, service users with mental health problems. Another male informant, however, does not believe in drawing on personal emotional issues in the professional role. This view suggests Hearn's (1987) argument that for men 'being professional' may mean not showing certain emotions. This relates to the wider

argument of Lupton (1998) that emotionality tends to be culturally coded as feminine, while lack of emotionality is dominantly represented as masculine.

A particularly fruitful area of investigation has been 'the male gender'. A male Mental Health Officer may have different gender experiences, such as, experiencing a power to dominate others and also experiencing discrimination against himself from others. The complexity of the male gender reveals itself even within an individual man's experiences. This suggests much to be explored in research terms on the male gender.

In conclusion, postmodernist and black feminist thought have encouraged a focus on the complexity of the social relations of gender. In relation to personal biography the gender analysis has not been simply one concerning the categories 'female' and 'male' as, for instance, 'victim' and 'oppressor' respectively. Instead, Collins' (1991) model, for example, theorises gender as interlocking with other axes, such as, age and sexual orientation, and it also analyses gender on several levels including personal biography. This approach has highlighted the complex area of emotional responses and gender in mental health social work. It has also highlighted the aspects of privilege and penalty relating to gender and the other axes. Examples include privilege relating to gender but penalty relating to older age in the case of men, and privilege relating to heterosexuality but penalty relating to homosexuality for both women and men.

The multiplicity and complexity of the gendered experiences of individual male informants have emerged through using this approach to personal biography. As well as regarding the male gender in terms of privilege, this focus on personal biography has encouraged seeing possible contradictions in an individual's experience.

I chose to study the male personal gender in this chapter rather than the female personal gender because much feminist research has concentrated on the gender of

women. My project contributes to the growing body of recent feminist research which includes the study of the gender of men.

Therefore, postmodernist and black feminist theorising, and particularly Collins' (1991) model, have encouraged a focus on the complexities of gendered experiences relating to the personal biographies of informants.

## **CHAPTER 6**

### **CULTURAL CONTEXT**

#### **THE GENDER CULTURE**

The cultural context formed by those experiences and ideas that are shared with other members of a group or community which give meaning to individual biographies constitutes a second level at which domination is experienced and resisted (Collins 1991, p.228).

In this chapter, I will draw from Collins' analysis of the *cultural context*, examining the cultural context of gender, or the gender culture, which operates in mental health social work. Gerson and Peiss (2000) argue that reciprocal processes of negotiation and domination elucidate the ways in which women and men act to support and challenge the existing system of gender relations. The gender culture is produced and reproduced in social interactions and also constantly negotiated and challenged.

The chapter is in two parts, each of which deals with issues focussing on different aspects of the gender culture. The first part of the chapter is concerned with commonality or shared experiences based on gender groupings. Abuse issues in mental health social work are examined as an example of shared experiences. The second part of the chapter is concerned with categorisations found in the views of some informants and based on the gender groupings, 'women' and 'men'.

In part 1, some informants, both male and female, assume the existence of commonality or shared experiences based on gender groupings. These shared experiences are usually constituted in terms of the service user and the worker relation, that is, female service user and female worker, and/or male service user and

male worker. The informants view commonality in different ways, for example, as commonality of oppression – usually between women, or as shared interests, such as sport – usually between men. Other related issues raised by informants are dependency, empathy, and shared biological experience.

In the case of working with someone who has experienced abuse, some informants' views are constructed in terms of commonality. For instance, the view that female workers should work with female service users who have experienced abuse is sometimes based on an assumption of shared experiences between female workers and female service users.

In part 2, gendered categorisations or shared ideas are sometimes found between informants. Firstly, the categorisations concerning women are presented and, secondly, the categorisations concerning men are presented. These are as follows: women and children; women and relationships; women and depression; men and aggression; men and a reluctance to talk; men and discrimination. Finally, a categorisation concerning both women and men is presented, that is, women, men and vulnerability.

## **PART 1**

### **Commonality or Shared Experiences**

Some informants assume the existence of shared experiences based on gender groupings. These shared experiences give meaning to individual biographies (Collins, 1991). The shared experiences are usually assumed in terms of the service



user and worker relation between female service users and female workers, as well as between male service users and male workers.

According to the early feminist social work literature (Wilson, 1972; Brook and Davies, 1985), the concept of shared experiences among women rests upon an assumption of commonality of oppression (White, 1995). This notion has been criticised more recently by many feminist theorists (White, 1995) as not taking account of differences, for instance, differences among women, such as heterosexual or homosexual orientation. Feminist theory is now often concerned with the production of differences, having made explicit the essentialist roots of theorising 'women' as a separate, identifiable collectivity (De Lauretis, 1994). Also, postmodern perspectives argue that there are no 'essential' categories which define people's experiences (Cree, 2000).

Hearn and Morgan (1990) argue that 'masculinity' and 'men' are socially constructed entities and that the terminology should be pluralised to masculinities. In this view, experiences of masculinity and of being a man are not uniform. Hence, social constructionism encourages theorising of differences among men.

In attending to differences among women and among men, however, it is important not to celebrate difference *per se*. Healy (2000) points out that Cixous, a leading French feminist writer, does not celebrate racist or patriarchal values even though these could be regarded as part of a spectrum of difference.

It is suggested that a focus on diversity can mask power differentials (Cavanagh and Lewis, 1996). In other words, recognition of diversity and particularly celebration of diversity could lead to a disregard for power inequities associated with such diversity. For instance, recognising and celebrating the difference of heterosexuality and homosexuality among women may lead away from realising the power inequity between heterosexual and homosexual women. Langan (1992) similarly argues that recognising diversity among women should not mean that the

concept of 'woman' is negated, or that the power imbalance between women and men within society should not be recognised. In answer to this conundrum I draw from Collins' matrix (1991) which theorises gender (female and male) in terms of both difference and power differentials.

The working relationship of a Mental Health Officer and a service user involves power relations and so for informants to assume *shared experiences* requires negotiation of this level of difference. White (1995) found, in a study of the relationship between feminist social workers and women service users, that workers experience some commonality with service users but also experience diversity amongst service users. For instance, not all female service users share a feminist perspective with feminist social workers. My project finds that some workers, both female and male, experience commonality in terms of gender.

One of those workers is female Mental Health Officer 12 who holds the view that there is commonality of oppression amongst women:

I am a woman in this society and we are oppressed and I don't just mean that I am today. I mean that I come from generations of women who have been oppressed.

This informant acknowledges the common experiences of oppression amongst women. This perspective negates, or detracts from, the argument that recognises differences among women. Commonality is a key theme of early feminist theory, as stated by Stanley and Wise:

'Oppression' involves an essentially shared set of experiences (1993, p.62).

Underlying this view is the danger of assuming that 'women' are in a fixed position of being oppressed, whereas 'men' are in a fixed dominating position. Such binary-divisional thinking leads to little further understanding of the axis of gender and how other axes, such as race, relate to it.

A related tendency is to interpret 'gender' as the 'problem of women' or a 'problem for women'. Male Mental Health Officer 5, for instance, relates gendered awareness to working with women:

I work with more women than I do with men....and they [women] tend to sort of keep you right with regard to that [gender] or remind me lest I forget that, which is assuming that women are better at gender issues than men

'Gender' is, then, categorised in terms of 'women' by this informant. This typification suggests understandings based on early feminist theorising of gender, as outlined earlier, in terms of the common experiences of women.

Female Mental Health Officer 10 bases the following view on shared experiences, that it is sometimes best for female workers to work with female service users, and for male workers to work with male service users. This view of matching workers and service users by gender bases itself on commonality within the gender groupings and seems to perpetuate difference between women and men. The informant cites an example of a female worker working with a female service user who has suffered sexual abuse as a child. There is an assumption of commonality of oppression amongst women based on notions of women as victims and men as oppressors. Collins (1991) takes the view that there are no victims and oppressors as such, since nobody is purely a victim or an oppressor. It is possible, for instance, that a female worker will not have had similar experiences of abuse to the female service user. Also, there are men who have suffered sexual abuse in childhood and so a shared understanding between a male Mental Health Officer and the female service user may occur.

Male Mental Health Officer 18 suggests that he is more able to work with male service users compared to female service users:

I think it [being male] is disadvantageous probably in working with women sometimes because of their preconceptions that they may have of what I

might be like, and my preconceptions of what they might be like or need so I think sometimes the gender role ...I think there is a struggle, there are many struggles in the world. This is a general answer, and one of the struggles is men trying to understand women and women trying to understand men, so I think that will be transferred, that will continue on to where I come in in a professional role as opposed to personal role in meeting with women, so I think there may be disadvantages sometimes in my ability to work with women and there may be advantages sometimes in my ability to work with men, with mental health problems.

This informant sees himself at a disadvantage in the workplace. He assumes that women have preconceptions of him and then acknowledges his own preconceptions of them. Informant 19 considers that 'struggle' is involved in trying to reach understanding across the genders – that is, women trying to understand men and men trying to understand women. He views this as a general gender struggle of which he has experience, and considers that it gives him advantages in working with male service users and disadvantages in working with female service users. He assumes that as a man, he does not need to 'struggle' to understand men.

Mental Health Officer 18's perspective rests on an assumption of commonality, such that difference involves struggle, perhaps even conflict, in understanding which unity lessens. Difference, then, is regarded as problematic. There are essentialist roots to such a view which divide the gender groups on the basis of 'what women are like' and 'what men are like'. This view upholds natural difference and perpetuates it into working relations. In the case of MHO 18, a general perspective of gender division is associated with gender-differentiated working relations.

Male Mental Health Officer 17 also indicates male gender commonality in the following example of his working with a male service user:

...So that was so in terms of engagement and beginning to attempt some discussion with him around ...that I was... you were able just to talk in general terms about the music he enjoyed and as I say we were of a similar age so there was kind of an unspoken thing there that we were at a similar stage in our lives even though he is a single man and I am not so not that we

were that similar, but you had some commonality to what you were about. So working with him was easy and I think it probably put him at some ease as well that I recognised his taste in music and the things he was doing, sports he enjoyed, the football and, you know, that kind of thing.

This informant expressed unity with the service user in terms of gender and age range, and also through similar musical interests, and through the more traditionally masculine interest in sport, specifically football. These personal similarities are viewed as helping to establish communication between the worker and service user because they make a connection. These similarities widened the scope of the working relation. The commonalities of the worker and the service user enabled them to discuss subjects other than what is expected to fulfil the MHO role in a technical sense. An assumption of a traditional conception of masculinity underlies the worker-service user connection and is considered to be beneficial.

Sometimes, female informants think that male workers should work with male service users and, sometimes, male informants think that female workers should work with female service users. This view, then, crosses the gender groupings and relates to the gender other than that of the speaker. It is based on a commonality which is believed to be experienced amongst the other gender group in the same way that it is thought to be in their own gender group. This view assumes that there are shared experiences within the distinct gender-differentiated groups.

Female Mental Health Officer 10, for example, focusses on unity in the male gender between male service users and male workers:

I suppose you know there are aspects of things probably in the same you know maybe in the same way for male service users where it is easier to talk to a male worker or that they might think that there is a shared experience there or something.

However, two informants, one male and the other female, do not consider that their gender has made much, if any, difference in the working relationship with service users. This view refutes the theory that commonality of gender is useful.

Male Mental Health Officer 20:

...my mental health work to date from a statutory point of view has been mostly with females so that has been that has gone reasonably well I would say and, you know, I don't necessarily think that it would have been different, I suppose that is hard for me to say really, but I am not sure that they would have got any better service had it been a female worker as opposed to myself...

Female Mental Health Officer 6:

I would like to think that the mental health whatever that is I would offer the same service to anyone regardless of what colour they are, what sex they are or whatever.

The perspective of female Mental Health Officer 6, particularly, suggests an individualistic approach to mental health work which does not take account of social groupings and discrimination. Both commonality and difference seem to be discounted in this approach.

Male informant 1, in relating how he connects with a male service user on a basis of traditional masculine interests, specifically football and cars, highlights a potential problem in male worker-male service user relationships. He states:

The six-foot-four weightlifter guy, and he's at home and I visit him every week and I have built up a really good relationship with him and a lot of that I have to say is also because I am quite willing to exploit things that we have in common, I don't know if it is exploit but do you know what I mean just that we have shared interests that I am able to talk to him about, traditional - football, cars and you know I hope I am able to do that in a way that isn't...not that he is necessarily behaving in ways...I suppose I pick up from again from my criminal justice days where you know you were always all really paranoid you would end up colluding with people who had really kind of questionable attitudes to women and children or really distorted attitudes to women and you were constantly having to monitor yourself that you didn't get involved in collusive relationships with offenders

The view of informant 1 is based on his experience as a social worker working within criminal justice, and which he translates to his work as a Mental Health

Officer. In building a relationship with the male service user, Mental Health Officer 1 reveals a concern of possibly validating what he sees as 'distorted' views toward women and children. The working relation could be endangered if the male service user has a 'distorted' view of women and children which the male worker is influenced by to the extent of collusion, according to this informant.

Several informants, female and male, raise 'distorted' male views of women as part of what they have seen in mental health work. What do these informants mean by 'distorted'? Mental Health Officer 1 does not explain what he means by 'distorted'. He also uses the words 'questionable' and 'collusive'. These words suggest some form of disrespect on the part of a male worker and a male service user towards women and children. This male informant seems to suggest that a shared patriarchal perspective could develop in the relation between the male worker and the male service user.

Male Mental Health Officer 1's construction of possible distorted views of women and children in a male worker and male service user relationship involves constructing women as 'other'. Being constituted as 'other' is a form of domination, in terms of social understandings and practices: De Beauvoir stated:

The category of the *Other* is as primordial as consciousness itself (1988, p.16).

Constructions of 'other', then, apply to gender but also to other forms of domination or oppression, such as sexuality, race, and disability. This type of thinking is rooted in the either/or dichotomy of additive models of oppression. Someone is *either* the oppressor, *or* the oppressed in these models (Healy, 2000). The 'other' can become a blanket-term for all that is outside the subject that has the power to name the other, that is, for everything that is not self-same. The effect of otherness, then, can be the erasure of difference, for instance, in the statement that all women share the same ontological and epistemological space (Moore, 1992).



Male informant 1's view of potential collusion between himself as a male worker and male service users derives from constructing 'women' as 'other'. He, along with male service users, can name women as 'other', as not self-same. This informant is, however, self reflexive in that he names this positioning of women as collusion with male service users, and this is something that he is wary of in order not to comply with it. Other men, then, may be able to put pressure on him to 'join the club' and name women as 'other'.

The construction of women as 'other' is a form of domination, then, which positions women as lesser through being blanketed as not self-same to those who name or define. This is a power, and in such views power is with those who name, that is, the oppressor rather than the oppressed. This does not, however, take account of power to resist and to self-define (Collins, 1991). Also, Foucault theorises power as limitless and productive, and co-extensive with knowledge (Ransom, 1993). Feminist theory is interested in power relations between women and men, and among women, and among men. There has been a growing recognition of the complexity of power relations concerning women and men (Featherstone, 1997).

Dependence is another commonality issue, this one raised by female MHO 14. She experiences some commonality between herself and female service users, leading them to become more independent of her, whereas male service users show more dependency.

Probably I find working with female service users to be more rewarding and that may be because they go on to live more independently and work much more closely with me and have similar goals that they wish to attain whereas male service users tended to be more dependent on me and the other professionals involved in setting up their support, so yes I do have a preference to work with women.

From her experience as a Mental Health Officer, this informant identifies these different ways in which female and male service users work with her. There is an identification between herself and female service users, which assumes

commonality in terms of gender. As a result of her identifying with the female service users, this Mental Health Officer finds working with female service users more rewarding than working with male service users.

Another interpretation of this informant's view is that she believes female service users are more likely to agree with her assessment and therefore they are easier to work with and achieve agreed goals, than are male service users. This interpretation is suggested in her statement that female service users work 'much more closely' with her.

Featherstone (1997) argues that for many men dependence is a problem because it contradicts the ideological basis on which masculine socialisation rests. This emphasises the importance of independence and self-sufficiency. It is interesting that female Mental Health Officer 14 has found male service users to be more dependent on her than female service users given the said contradiction. A stereotyped view of gender difference in terms of dependence and independence does not explain this informant's statement.

Mental Health Officer 14's experience of working with men is not constructed by her in terms of categorised, fixed positions, such as male = independence. There is a fracture between the categorisation and informant 14's experience of male service users as more dependent on her than female service users. The typification misses out on the complexities of masculinity, whereas her experience crosses over the typification in the Schutzian sense as interpreted by Stanley and Wise (1993). That is, her experience does not follow the categorization.

Female Mental Health Officer 8 focusses on the issue of empathy in working relations with female service users:

...about women who were being admitted to hospital with puerperal psychosis, I think being female did help me and at that time I hadn't actually had my own child, but I remember that I did actually that it did make quite

an impact on me that, you know, I felt that the service we were offering wasn't really good enough for that situation, and sort of getting involved with a pressure or sort of working with a pressure group looking to see how some difference could be made, some change, improvement how people were treated in that situation and I maybe wouldn't have had that same interest in a male issue.

This indicates a limited sense of commonality since the informant formed her view prior to having a child herself. She builds her perspective on a basis of empathy or placing herself in the service user's position in an attempt to understand it. As a result Mental Health Officer 8 decides to try to make a difference in the situation of service users who were hospitalised due to puerperal psychosis.

Hanmer and Statham (1987) argue that empathy in social work is based on recognising commonalities, and inhibits the 'you ought' response (White, 1995). White (1995), though, is of the view that empathy cannot be considered outside the context of the power relationship which exists between a female social worker and a female service user. She argues that empathy can be regarded as an aspect of that power relationship in that, for instance, the social worker has some choice over whether to empathise or not. If female Mental Health Officer 8 had not empathised with the hospitalised service users, she would not have tried to make a difference in their situation.

The social worker and service user relationship is socially constructed and never purely a technical transaction. It is mediated by a set of assumptions on either side (Clark and Asquith, 1985). Informant 8, in attempting to make a difference in the lives of service users because of empathy, indicates that the interaction is not merely technical.

Another area of assumed commonality by some informants relates to shared biological experience. Male Mental Health Officer 20 states:

...with more specific mental illnesses that are specific to women, the sort of post natal stuff again, and perhaps other women who have had children would have had perhaps a bit of depression are in a better position than me to understand what it may be like for a woman who has got post natal depression.

This informant considers that he does not share experiences with female service users in these instances because the basis of commonality between women is taken to be biological. This view has an underlying basis of biological determinism, in that biological argument is being drawn on to suggest that a female worker would be better than this informant, who is male, to work with female service users who experience post natal depression. Feminist theory has criticised and mostly rejected biological determinism, the modern version of which is sociobiology. Kramarae and Treichler (1992) state that sociobiology attempts to explain the origins of gender-differentiated roles in terms of biology, and in so doing they assign natural causes to phenomena of social origin. As I outlined in Chapter 3, biological theorising does not adequately explain differences among women and among men.

Some informants' views, then, suggest commonality between workers and service users in mental health social work based on gender groupings. These views do not highlight differences among women. Some of these informants' views focus on common experiences of oppression amongst women. Commonality of oppression was explored in early feminist social work literature, and has been criticised more recently by many feminist theorists as not taking account of differences (White, 1995). Also, commonality or shared experiences between men are highlighted in some informants' views, such as, a traditional male interest in sport. However, some informants' views indicate a lack of commonality, or difficulties in commonality, in mental health social work.

## **Abuse Issues**

The gender culture will now be examined in relation to issues of abuse in mental health social work. This cultural context which is constructed and reconstructed informs same-gender working relations and across-gender working relations.

A principal way in which the topic of abuse is constructed in Mental Health Officer views is in across-gender terms. This involves the working relationship of a male worker and a female service user. The female service user has experienced abuse at some time, and some informants view the same-gender working relationship of female worker and female service user as more appropriate than that of male worker and female service user.

Mental Health Officer 18 relates situations of discomfort to him as a male worker.

He states:

The time I give it most thought is when a woman...what is on the table is the fact that she has sort of been abused or you know raped, some sort of sexual or violent crimes done against her and it is almost always by men and I think how will that influence you know my ability to make an assessment as a MHO or to work with her as a MHO or a social worker or even to be in the same room as her if she is going through some sort of trauma...so I like to think that...I have an awareness of all that, so that is what I have to say on that.

These are circumstances where this male informant clearly is of the view that his gender matters, that it makes a difference, but in a negative way. He is questioning his ability to carry out the Mental Health Officer role in the situation of working with a woman who has been abused in some way. He does not state exactly why he is questioning, instead relating the scenario and, in my view as interviewer, assuming that I will understand the difficulties he considers himself to be placed in. Given that this informant has elsewhere talked of transference in Mental Health

Officer work, for instance, in the relation of service user and worker, it is probable that what he is concerned with is transference from the female service user towards himself in relation to her male attacker. In such a perspective there are assumptions of commonality of experience in terms of the gender groupings 'women' and 'men'. The informant views the female service user in terms of victimisation but views himself as part of the male group which oppresses, and it is this identification of himself that seems to cause him to be uncomfortable as a male social worker.

This informant seemed defensive in stating 'so that is what I have to say on that'. From the perspective of interviewer, this had the effect of finishing that part of the interaction between Mental Health Officer 18 and myself. It could be that reviewing these situations led this informant to want to end that part of the interview.

At a different point in the interview, male informant 18 outlines a specific situation in which he felt uncomfortable:

...with a woman who has been detained several times where she has a terrible story of all the worst sorts of abuses and neglects, and I felt like just another man exercising control over her...where a male doctor wanted to detain her, I was the Mental Health Officer so I did it in...sort of one step removed because she was so distressed and distraught....so I spent as short a time as I could with her just explaining what I was doing...I think it would have been easier for her and for me probably, I am revealing more than I want to reveal, no but I think it would have been easier for her to have had a female Mental Health Officer although it wasn't a serious enough case. I suppose maybe in some cases....I might ask you know if a female Mental Health Officer could be involved but I haven't thought of doing that yet, I think I have just thought 'Oh well this is what they get, they get me today and I happen to be male so it's just tough really'.

Initially, this Mental Health Officer is of the view that the female service user finds it difficult to work with him because he is male. This difficulty relates to her history of abuse, presumably from men, and her emotional state while being interviewed. Informant 18 reveals that it is probably also difficult for him to work with her. He appears to regret suggesting his own difficulty towards working with the female



service user by stating: 'I am revealing more than I want to reveal'. This indicates how he feels concerning this piece of work but on reflection he is uncertain that his own emotional state should influence his professional perspective in this way.

The informant also states that in his work as a Mental Health Officer he has not requested a female worker to take over from him. In stating, 'I happen to be male so it's just tough really', his view indicates that he has doubts as to whether substitution of workers is appropriate in these circumstances. This is surprising because he considers that it is probably best for the female service user to work with a female Mental Health Officer and not with a male Mental Health Officer. Perhaps it is difficult for him to recommend substitution in a personal sense, that is, that he should be substituted by a female worker.

Male informant 5 relates a similar experience of working with a female service user who has had negative experiences with some men and how that also affects their working relationship. He states:

I have a [female] service user who suffers from manic depression...and I thought 'you're a lot better with a female worker to talk to about some of these situations because I am finding it incredibly difficult to relate to that, and also it must be kind of threatening for you that we have to spend time with each other on our own as is necessitated by the way we work'.

There is an underlying assumption here that if the service user and worker were of the same gender that would mean having shared knowledge. It is assumed that there would be shared knowledge between the female service user and a female worker. Also, a gender difference is assumed by the informant between himself and the female service user in terms of life experiences. In fact, he finds it difficult to 'relate to' the experiences this woman has had with some men. Despite having a professional role, this male informant considers that the female service user must feel somewhat threatened by working with him and having to spend time with him. Gender or the categorisation of gender, is a large influence in this situation.



He further states:

...if you [female service user] have had a bad time from men as a lot as I think a lot of the acute patients have done, it's unfortunate that you are supposed to be answering questions by a male worker, but you know I don't think there is a way round that...it would be too easy for me to cop out and say 'I'm not doing that'. What I tend to do is say 'are you comfortable speaking to me about this, you have to speak to me about this because this is my job or at least I have to ask you the questions, you can do this with a woman if you don't feel comfortable speaking to me by yourself'.

Here, this male informant states that he would ask the female service user if she is comfortable working with him or not. In circumstances where the service user has previously experienced abuse from men, he tends to assume that she will not be comfortable working with him. He thinks it is 'unfortunate' that the female service user has to work with him, that is, a male Mental Health Officer. It is suggested though, that the service user may have a different view, for example, she might be comfortable working with the male Mental Health Officer. It is possible that she may regard the professional role, or individual personal characteristics of the male Mental Health Officer, as overriding different gendered aspects of the relation. However, should she be uncomfortable with him, then it is suggested that a female worker could be brought in to possibly work jointly. Informant 5 does not consider it to be a reasonable option that he opts out of the working situation.

The perspectives of these male Mental Health Officers are constructed in terms of the gender culture which assumes shared knowledge between women but not between women and men. The trend of the male informants' views is towards uncertainty of how to carry out work with women who have experienced abuse from men, or even whether to carry out such work. There is a sense of unease and discomfort, to varying degrees, from these informants towards working with such female service users.

The gender culture of 'female' as 'victim' but 'male' as 'oppressor' constructs these informants' views of working relations and issues of abuse. The female service user

who has experienced abuse is viewed as being oppressed. The male worker is viewed as an oppressor and, in the female service user-male worker relationship, he is conceived of as a potential source of risk. Usually, the conclusion by the male informants is that a female worker would be best to work with the female service user. The female Mental Health Officer is not constituted as a source of risk, since being female she is associated with victimhood. The difference between the female and male worker in these views is not at the professional level but at the level of gender in the service user-worker interaction.

The categorisation of 'victim' and 'oppressor' is also made by Burns (1992) when she considers the treatment of women and men under the Mental Health Act. Women tend to be kept in less restrictive settings than men, Burns argues, as society is regarded as needing much greater protection from 'mad' men than women. She suggests that women are categorised as 'victims' and men as 'aggressors'.

Healy (2000) argues that the politics of *ressentiment* categorise 'oppressor' and 'oppressed' as fixed, and that the 'oppressor' is responsible for the oppressed status of the other. She states that the fixed politics of *ressentiment* are not transformative because they pre-empt investigation, such as, examining how the subject positions of 'oppressor' and 'oppressed' are constituted. Individuals are regarded as passive victims of their identifications. This categorisation forms part of these informants' gender culture of mental health social work and leads towards questioning the fixed status of such thinking.

Christie (2001) theorises men in contemporary discourses of welfare as representing both sources of risk and offering the potential to reduce risk. In relation to the topic of abuse, the male workers are sometimes constituted as sources of risk – to female service users.

Various informants' views determine difference and division in either/or terms, that is, as either 'victim' (female) or 'oppressor' (male). The concept of commonality or

shared experience, for instance, between women, appears to necessarily invoke the risk of essentialism. Theorising 'female' and 'male' in essentialist terms tends to assume differences 'in essence' between women and men (Busfield, 1996). These differences are often assumed to be biological. This is indicated in the examples of Mental Health Officers working with female service users who have experienced abuse where women are constructed in biological terms as 'weaker' than men and so vulnerable to abuse, particularly sexual and physical. In this view, women workers should work with women service users because of shared, biological, experience.

The assumptions, in the view that female workers should work with female service users who have experienced abuse, are that there are common experiences between female workers and female service users but different experiences between male workers and female service users.

Another gender difference which constructs some informants' views is that male service users are sources of risk – to female workers. Male workers can be constituted as having the potential to reduce such risk.

For instance, female informant 12 states:

I think there has been an occasion where I've thought that a male colleague might be better working with a specific [male] service user, and there has certainly been one mental health case where I thought that would have been more appropriate because the patient involved was particularly abusive towards women.

In this view, a male worker, rather than a female worker, should work with a male service user because the service user is abusive towards women. The female worker is categorised as a potential victim, and the male service user is categorised as a potential source of risk. The male worker is constructed as having the potential to reduce risk. This, then, is different to the situations outlined earlier of male worker-female service user interaction where the service user has suffered abuse and she is constructed as victim and the worker is constructed as a potential source of risk.

Christie's (2001) argument, that men in discourses of welfare are represented as both sources of risk and having the potential to prevent risk, is applicable to male mental health social workers.

An example of an oppressive sexualised service user-worker interaction is given by MHO 20:

...there are some of my caseload who have had mental health problems...and some of the reason I have been involved with them is because they specifically ask for a man because it has been highlighted that it would have been inappropriate for a woman to...be involved...one man in particular I am thinking about is very, very, sexual and is always talking about his contact with women and so on and it was suggested that a male worker should be involved with him so I became that male worker..... they [male service users] seem to respond better to a male worker so if that is the case then I think it is appropriate to respond to that...

The example given by this informant indicates that the male service user is potentially abusive towards female workers in a sexual sense. The informant is of the view that substitution of male for female workers in such circumstances is acceptable. The categorisation of the 'female' worker as potential 'victim' but of the 'male' service user as potential 'oppressor' can be seen in this perspective in relation to issues of abuse.

Situations of abuse may involve children. Male informant 17 worked with a female service user who had experienced sexual abuse. This abuse had a profound effect on her towards children:

There was a case of a woman who had been seriously sexually abused over a protracted period of time as a child, and there were parts of her life which were significant for her which...we discussed...where she would have felt more comfortable working with a woman [worker] and that is understandable. We couldn't quite get round that because nobody else would take her on, she was a very problematic woman who was incredibly risky in what she was doing and was threatening to..... kill babies and young children and had a whole range of strategies and ways in which she was going to do this...and had actually had gone with a couple of children...spent time in Cortonvale [prison] anyway so she had a very

difficult history and even though I'd said she would prefer to work with a woman none of the women in the team wanted to really take it on [working with the female service user] which wasn't a great surprise to me.

Another level of complexity relating to the categorisation of 'victim' and 'oppressor' is indicated here, that is, between children and women. The female service user has experienced sexual abuse which it is suggested is linked to her threatening behaviour towards young children. This behaviour indicates assumptions of children as vulnerable in relation to women. The cultural division of 'women' and 'men' is now complicated by the additional category of 'children', and it incorporates the construction of 'women' as a source of risk.

Featherstone and Trinder (1997) point out that in radical feminist domestic violence research (e.g. Hester and Radford, 1996), women are constituted as the victims of abusive men, always done to rather than doing, but they are also constituted as fierce protectors of children. There is an assumption that the interests of women and children coincide. This coinciding is not the case in the example of abuse and its effect given by informant 17 since it is a woman who is placing children at risk. Featherstone (1997) argues that the decentering of masculinity and the destabilising of subjectivity has led to a recognition of the differing power positions which women occupy in relation to other women, to men and to children. Postmodernism argues that there are multiple and contradictory subjectivities which are produced by discursive practices. Gender relations, then, are complex and fluid among women, men and children.

Another aspect of working relations, which was touched on earlier, is that of female workers and female service users sharing common 'ground'. This is based on assumptions of gender culture concerning the topic of abuse, particularly sexual abuse. Mental Health Officer 2, female, states:

I think...we are always coming across things like somebody with mental health problems who has had experience of sexual abuse, for example, I think there are advantages to having a female worker...I mean I am actually

dealing with a lady at the moment who has a history of sexual abuse, physical abuse as well, and I think certainly there have been male Mental Health Officers working with her in the past...when her last Mental Health Officer was moving on who was a male he actually recommended that a female Mental Health Officer works with her so I think there are advantages in circumstances like that in having a female Mental Health Officer involved.

This female informant's view suggests that it is best that work with a woman who has experienced abuse is carried out by female workers. There are underlying assumptions in this view of gender culture as shared experiences or ideas between a female worker and a female service user. One assumption is that it is usually women who experience abuse. Another assumption is that a man, or some men, have been responsible for the abuse, and that consequently it is not so appropriate for a male Mental Health Officer to be involved. This perspective echoes previous male informant views but because this is put forward by a female informant there is not the personal gender struggle which is evident with some of the male informants. This is because female Mental Health Officer 2 does not consider that she needs to opt out of the work or make other arrangements in relation to working with such a service user. From her perspective, it is appropriate for her to carry out this work rather than a male worker.

Female informant 6 also holds to this view:

I worked for quite a while with a young woman who had a series of tragic things happening to her in her life and she was very low self-esteem, and she mutilated herself a lot, and she found it easier to talk to me because I was a female [rather] than a male...and in fact in the package of care that I had to set up for her she specifically asked that the support worker who was going to be in place, 'could it be a female?', and I think yes that was certainly a positive for her that she did have female workers.

The tragic occurrences in the service user's life are not specifically related to a man or men, although this is suggested in her request that she work with a female and not a male Mental Health Officer. According to this perspective, the female service user regards shared gender with the social worker as a positive aspect of the



working relationship. The assumed commonality is seen as having a beneficial effect in this view. The commonality suggested is one of victim-hood, given the indicators of low self-esteem and self-mutilation. Barnes and Anderson Maple (1992) suggest commonality in their argument that, in women, low self-esteem and sexual abuse are related to mental health problems.

Female informants 4 and 11 also are of the view that being a female worker is advantageous when working with female service users who have experienced abuse. Female Mental Health Officer 4 replies to the following question:

RM: Based on your experience of mental health work do you think the fact that you are a female Mental Health Officer has been advantageous in any way to understanding mental health difficulties or do you think it may have been disadvantageous?

MHO: I don't know either or to be honest I mean I think there has been some situations, particularly when I worked in West Lothian I was involved in doing a women's group about sexual abuse, a number of women at that time I worked with had been abused, and I suppose it [being a female MHO] was [advantageous] in that situation.

Female Mental Health Officer 11 states:

MHO: ...once or twice I've found where there have been issues of sexual abuse that haven't previously been disclosed or have only just been disclosed, that I think it has been helpful to be female [worker], in those kind of situations I think it has helped

RM: And that is women that are disclosing?

MHO: Yes

Again, there is the assumption of shared knowledge based on gender in that there is an area of knowledge which stems from being female and which female persons share but which male persons do not share. In this context of abuse issues, the sharing is in relation to the category 'male' and the knowledge is based on negative experiences. However, both female and male persons can experience sexual abuse from either gender, though the general trend is that more women suffer sexual abuse from men than vice-versa (Busfield, 1996). Male accounts of experiencing abuse



stand against the gender culture, and highlight that exceptions do occur to 'male' being associated with 'oppressor'.

An example of abuse experienced by a man is given by male informant 18 when he describes being attacked whilst on holiday. He relates this experience to his work as a mental health officer:

When I was in South America I was seriously assaulted by five strangers wanting my money and I was very frightened....they didn't actually do me any damage it was just...it was a bit like plundering somebody, they just went all over my body looking for money belts and hidden supplies of money, I felt quite seriously abused by it.

This example stands out from the rest of the interviews because the speaker is male. The culture of film, media, television, literature and so on includes many influential examples of abuse experienced by women but not so many examples of abuse experienced by men. It is, therefore, quite unusual to listen to or read an account of abuse experienced by a man. This male informant has known how it feels to be afraid and abused, and he further states that he uses this feeling as the 'baseline' to work from in terms of any elements of fear and risk as a Mental Health Officer.

His perspective as a MHO includes knowledge of himself as vulnerable and as open to 'risk from others'. It is helpful to consider the both/and conceptual stance of Collins' (1991) model, which points out the aspects of penalty and privilege within axes of domination. Informant 18, being male, is privileged in terms of gender but he has also suffered an abusive experience. In this perspective, he is not an absolute oppressor or an absolute victim. There are no such 'absolutes' in this explanatory model of domination since it encompasses variation.

The gender culture of mental health social work, then, has been found in some informants' views to consist of associating 'female' with 'victim' but 'male' with 'oppressor' in relation to the topic of abuse. However, variation has also been found, such as discomfort experienced by male workers in working with female

service users who have been abused. Theorising gender as created and recreated in social relations, rather than fixed and stable, helps to account for such variation. That is, women are not always 'victims' and men are not always 'oppressors'.

## **PART 2**

### **Categorisations**

Busfield (1996) argues that gender is involved in mental health work though not necessarily directly. She states that official constructions of mental disorder are almost entirely gender-neutral and yet they are indirectly related to gender since they construct 'as problems of mind...feelings, mental processes, and behaviour which are themselves gendered' (1996, p.117).

In this section, I examine the use of gendered concepts by the Mental Health Officers and what this use means to their mental health social work practice, for example, their assessments and decision-making.

Views in the literature differ as to whether gender is relevant in terms of mental health and mental health services. For instance, Barnes and Anderson Maple (1992) state that the question of gender is rarely seen as an issue to be explored in decisions whether or not to invoke the power of Mental Health legislation. Burns, however, argues in relation to the discourse of mental health services that it is 'clearly and actively gendered' (1992, p.107), with subsequent different outcomes for women and men.

Gendered categorisations, or shared ideas, are examined which relate to the groupings 'women' and 'men'. Firstly, the category of 'women' is studied and secondly the category of 'men' is studied. Finally, a categorisation concerning 'women', 'men' and 'vulnerability' is examined.

These shared ideas of informants constitute part of the gender culture of mental health social work.

### *Women*

The categorisations or typifications which are found in the views of some informants concerning 'women' will be looked at in this section. These are 'Women and Children'; 'Women and Relationships'; 'Women and Depression'.

#### *Women and Children*

The categorisation of 'women' and 'children' is found in some informants' views, usually in the sense of a mother and dependent children relationship. There is evidence of a differentiated view in relation to female and male service users with children. A related difference is also evident in areas such as assessment of need and care provision.

Male informant 15, in response to being asked whether there is anything that he would take into account differently depending on whether a man as opposed to a woman were being considered for 'sectioning', states:

...not especially although if there were children involved I suppose I tend to take that as more of...an issue for a woman than if it was a man with a spouse or partner still looking after the kids. I think we always tend to

assume if the father is at home with the kids then there is a bit more of an issue about parenting you know and getting Mum back into that role if that is where she is normally used to be you know than if it was the other way round.

This Mental Health Officer's perspective incorporates differentiation in terms of female and male service users with children and the mental health issue of detention. He specifically mentions the role of mother and the probable need to maintain that role, for instance, taking the female service user 'mother' out of detention sooner than the male service user 'father' in order that she can continue to take care of the children. The decision-making of this Mental Health Officer has been influenced by the roles of 'mother' and 'father'. The typification underlying this view is that of 'women' linked to 'children', and that culturally women still carry out most childcare related tasks. There seems to be an assumption in the informant's view that women are better able to parent than men.

Russo (1984) states that a woman's identity is defined in terms of her childbearing and child rearing roles, and she suggests that this identity can negatively influence mental health. She further argues that this cultural context appears to affect even women without children. This is a wide-ranging argument, then, concerning the cultural connection of 'women' and 'children' which is indicated in some informants' views.

Female informant 2 makes this connection in relation to 'sectioning':

...it would depend on the circumstances if, for example, it is a woman who is a single parent, for example, then obviously one would have to consider the needs of the children whereas if it was a man living on his own it wouldn't be the same issues around children and that is something you have to think about all the time you know circumstances yes. That would be the main one I would think of in how I would treat male and female differently.

This informant's examples connect children to female service users but not to male service users. This connection results in differentiated decision-making on her part as a Mental Health Officer. She takes account of the needs of children in relation to

female service users on a routine basis. That is, the presence of children influences her 'sectioning' decisions and because it is women who typically look after children, it is women who are more often going to be affected.

Female informant 8 focusses on the relevance of relationships, particularly those of women and children, to professional mental health perspectives:

I am sure there are different pressures on people at different times in their lives, sort of women with children who are becoming ill have different pressures on them and that affects how they are going to receive treatment, how they are sort of perceived by us and medical people and...it will dictate to a large extent how they are treated...so it's people roles and responsibilities which is to do with their relationships with others. I suppose I am thinking about family relationships.

According to this informant, professional perspectives towards female service users are constructed in terms of relationships, such as whether they have children. This MHO states that such relationships are a multi-disciplinary consideration. They are taken into account by Mental Health Officers and medical staff. The result is differentiation in assessment and treatment towards female service users with children in comparison to others without children. This is gender-based since it is only female service users with children that this informant mentions in this context, and not male service users with children.

Male Mental Health Officer 20 suggests an awareness of discrimination in his view relating to 'sectioning':

I don't ...how to say this without sounding sexist, I have to really think about what I am going to say...I am sort of not really sure....whether the childcare issues as well if it is a single parent, are there other alternatives to support for the mother and child as opposed to a ward environment which is not obviously ideal...

This informant hesitates in giving his view with regard to childcare issues, although this is a subject that he raises himself. He is concerned that he may sound 'sexist'.

It may be because he is male that he is concerned his view could be 'sexist', since it emphasises a link between women and children. This indicates that reflection on his own perspective makes Mental Health Officer 20 consider that it may involve discrimination because he makes a connection specifically between childcare and the mother role, not the father role, and that this connection might make a difference with regard to assessment for detention. For instance, alternatives to hospitalisation could be more pursued in the case of a woman who has a child(ren), presumably to attempt to maintain the relationship(s). However, this could lead to quicker hospitalisation of men without children if alternatives are not so readily sought by the Mental Health Officer.

Male informant 19's view shows that children can be a focus of mental health decision-making:

Maybe when we are taking someone into care...a single mother with kids...definitely could have had better supports and all the rest of it but she just kind of stopped doing anything for weeks so eventually we had to do something, bring the kids in [to] care, we got her detained and through all of that that worked OK that time...and that was definitely the circumstances we are talking about very very I suppose immediate life...

The emphasis which this Mental Health Officer places on the circumstances of the female service user, and that she 'stopped doing anything for weeks', indicates that her children were a central focus of decisions made. The children were taken into care and the service user detained. If she had had no children perhaps the difficulties she had would have been regarded differently. For instance, not 'doing anything' for herself might not be seen as such a high priority as when the care of children is involved, especially in the situation of a single parent.

These views tend to assume that assessment of mental health is tied up with role, particularly the mother role in relation to female service users. This poses the care of children as a legitimate concern in determining the mental health of the female

service user. In such views how a woman fulfils the mother role is taken as an indicator of the status of her mental health.

Female Mental Health Officer 11 suggests that women's relationships tend to be considered in professional views:

I mean I think if you are a depressed man, a depressed woman, you are depressed, become miserable whatever your gender is, but how that is dealt with I think might be different. Men I think would tend to be treated more medically, more in isolation, whereas women generally I think...would be seen more as ill, whereas I think that women generally speaking have to 'bloody' well get on with it whether they are ill or not, so there is other approaches to them like child care issues and worries about their ability to look after kids, groups where they can go and talk...

This informant reacts emotionally in talking about women stating that they have to 'get on with it', irrespective of whether they have mental health problems or not. Also, Mental Health Officer 11 highlights that male service users tend to be considered as individuals, whereas female service users tend to be considered in relation to, for instance, childcare issues. The female service users are regarded in relational terms and male service users are considered more in their own right. This Mental Health Officer appears to raise the point that discrimination occurs in terms of female service users being seen as having to 'get on with it'. It is the care of others, particularly children, which is the basis of this comment. In other words, it is suggested that the mother role is the relevant factor in how women are viewed generally and also specifically in mental health terms.

Different circumstances are raised as an issue by female Mental Health Officer 14. She states:

I suppose while working with women I might spend a considerable amount of time looking at their social circumstances, for example, if they are a single parent mother who has other issues that they need to consider, I am not sure whether I am not sure that any male Mental Health Officer would act any differently but certainly they [social circumstances] have often been



the issues that I have considered as a priority before the sort of treatment model .....[in relation to men] perhaps focussing more on the yes the immediate treatment plan or need to be in hospital but again it is probably more due to their social circumstances not having the same components in them so they don't have to consider the care of any other dependent for example...

The social circumstances of women and men in general are considered by this informant to be different and this is taken into account in her work as a Mental Health Officer. She sees the mental health and the circumstances of female service users as the important issues. With female service users she considers it more likely that there will be childcare issues than with male service users, and this leads her to look more directly at the mental health concerns of the men. With female service users, this informant looks at mental health after social circumstances. The context of mental health, then, is taken as variable between female and male service users. Also, Mental Health Officer 14 seems quite defensive in her statement that she does not necessarily think that a male Mental Health Officer would take a different stance to her own.

Male Mental Health Officer 15 strongly connects women with family issues, particularly childcare:

MHO:...women are seen to be out of control of their almost emotional side that they are that they act irrationally or they act you know I suppose they are really flat whichever bit you are seeing it, and that I think that seems to correspond to they are not functioning well...and how we see that functioning whether it is I think we probably do see that functional bit as something to do with family or you know community type of how you network into where you live

RM: For both [women and men]?

MHO: Well a lot more for women I suppose...because of their hysterical behaviour, if there is children seen to be around then that clearly gets neighbours or whoever very anxious but if a man is you know that way having the same sort of problems then I am not sure if it as early on seen as such a big mental health issue because there is a kind of buffer between him and the kids if there is a woman around...

Women are assessed in terms of function, in this perspective, and this is connected to family or community. What is highlighted is that role is relevant in terms of the assessment criteria of women in relation to mental health. MHO 15 states that when women are not functioning well, and this seems to be in terms of role, then, they can be seen as irrational or very 'flat'. This judgement is based on their perceived emotional state. For instance, how well a female service user carries out the role of mother, in this view, relates to her mental health status.

This informant uses the term 'hysterical' in relation to women as mothers, in stating that a mother's hysterical behaviour which impacts on children is judged as a problem by others, such as neighbours. Yet, similar behaviour by men as fathers is not necessarily assessed in the same way because women act as a 'buffer' between them and children. The word 'hysterical' has historically been attached to women's behaviour. Showalter (1987) states that the very name of 'hysteria' derives from the Greek *hysteron* or womb. She argues that by the end of the nineteenth century, 'hysterical' had become almost interchangeable with 'feminine' in literature, where it stood for all extremes of emotionality.

In MHO 15's example, taking responsibility for the care of children in a direct rather than indirect way results sometimes in mothers being judged more severely than fathers. The suggestion from this informant is that this is the case as a general perspective towards mothers in society and also as a specific mental health perspective.

Women are linked to children again in a caring capacity. Cree (2000), as stated earlier, argues that ideas of women having a 'natural' capacity to care lead to harsh judgements of women who do not live up to this stereotype. These harsh judgements are suggested in informant 15's view, and also could reflect the discrimination to be found in some views. This is based on a differentiation between female and male service users who have children.

From the way that this male Mental Health Officer puts this view, it appears to be inclusive of his own perspective. For example, he uses terms, such as 'how we see that functioning' and 'we probably do see that'. It is the inclusive term 'we' that indicates his involvement. As such, his view suggests discrimination towards female service users in that they might be judged on a more stringent basis than male service users in relation to carrying out a parental role.

Again, male service users are being assessed more in their own right, whereas female service users are assessed more in relational terms. Gilligan (1982) argues that relationships are experienced differently by women and men. She sees women as more embedded in relationships than men. This will be expanded in the section 'Women and Relationships' later in this chapter.

Mental Health Officer 15's statement highlights that this distinction is leading to different standards being applied between male and female service users, to the point that the 'same' behaviour from a male service user will tend to be judged less harshly in mental health terms than from a female service user. This male informant places mothers in a protective role between fathers and children. If a father, for example, exhibits hysterical behaviour then this is not assessed so critically as in the case of a mother, because with the father there is probably not as much risk to children due to the protection afforded them by the mother, according to role. In other words, the responsibility for the consequences of the father's behaviour can be indirectly placed on the mother in relation to children in this context, whereas the responsibility for the mother's behaviour is placed on her.

Dominelli and McLeod (1989) criticise mainstream social work, from a feminist perspective, because it constructs one of the social problems which it deals with as the ineffectiveness with which women fulfil their socially ascribed roles. They suggest that this construction points to individual women as 'the problem' rather than gendered social relations. Judging women differently from, and particularly

more severely than, men in mental health terms and in relation to role, does suggest that unfair assessments and decisions might be made.

Busfield (1996) states that in relation to mental health assessments, coping and managing are often judged in terms of the performance of gender-assigned tasks and duties. The responsibility of childcare is an identified female task by various informants.

Female informant 11 sees this task as adding pressure on to women:

I think women if they have kids have that additional dimension which no matter how supportive or helpful the husband is there is still that part of a woman's existence that I think is very significant and can add just that extra pressure that can perhaps tip over, tip somebody over, or just overburden somebody...

From this perspective, having children to take care of can add to the mental health stress of a woman, that is a mother. This female Mental Health Officer places this in the context of women and children being linked much more directly than men and children. Again, the mother role is central to this view in terms of the relationship of mother and child.

The World Health Organisation (1994) states that the social roles of women, for example, as mother and carer of children, put them at greater risk of stress than men. It argues that women are more vulnerable to mental ill health because of their unequal socio-economic status and the stresses they face as a result. Problems of alienation, powerlessness and poverty are more acutely experienced by women than by men, and these are generally associated with mental disorder. Women who are single parents, for instance, especially those on low income, are at high risk of depression.

From the views outlined so far, both female and male Mental Health Officers hold to some differentiation in view between female and male service users in relation to

the care of children. This differentiation in view can have an influence on assessment and decision-making in mental health social work.

Other views put forward by some female informants could be termed 'feminist' by, for instance, looking at childcare issues in a way which questions the connection of 'women' and 'children'. It is interesting that it is female informants who do this.

Female informant 7 states:

I think you really in some respects have to understand the broader concept of our culture...that women are always generally speaking brought up to please others, to be the providers, to be the housekeepers, and even women who in the 1990s work full-time, have two young children, have a partner, in principle the partner might say 50-50 but I think in lots of households it is the women who are still making sure the children are at school, if the child becomes ill if the children become ill often they are the first to contact, leave their job, the meeting whatever, they are still the ones with the coop bags, the tin of baked beans and fish fingers that are making sure the kids are getting that at six or whatever, I think they are still the ones making sure that they are off to the piano lessons or whatever, and I don't think that women actually really are allowed to ever think for themselves what their needs are...

This Mental Health Officer has taken a feminist view of the care of children in this culture. She is clear in her statement that it is principally women, and not men, who take care of children in this society. However, it is the last part of the extract which suggests that her perspective is a feminist one, that is, 'I don't think that women actually really are allowed to ever think for themselves what their needs are'. Informant 7 is placing women and their needs at the centre of this analysis. This implies that the needs of women are not necessarily focussed on the care of children.



The Male Link (2000) research project interviewed 632 men and found strong support for the view that men can care for children equally as well as women can care for children. This suggests that there is no necessary link between women and



the care of children, in the views of those men interviewed. This is similar to the perspective of MHO 7.

Featherstone (1997) suggests that there is no essential caring link between women and children because the range of subject positions which are open to women, men and children have proliferated enormously, as a result of the destabilising of subjectivity. The latter is a theme of postmodernist thought. Many postmodernists reject the idea of a rational and unified subject as knower, and argue instead that there are multiple and contradictory subjectivities which are produced by discursive practices (Schwandt, 1997).

Female MHO 12 points out gender differences in hospitalisation processes because of children's needs:

...if you look at the wards up here [hospital] there are usually more men in than women, that doesn't mean to say there are more men ill but men can stop work and come into hospital, women can't they have to stay at home and look after the kids.

She is clear in the view that gender-differentiation occurs concerning which service users are hospitalised, in that even if hospitalisation is advisable for a woman it may not occur because of childcare responsibilities. If a woman with children has mental health problems and needs hospitalisation but this is not made available, the question arises of how this omission affects these problems and also how it affects her abilities to look after children. The consequence could be concerns with regard to both the children's needs and those of the woman. On the other hand, a difficulty in hospitalising a woman, for instance a single mother, could be that her mental health becomes more stressed if she is separated from her children. Such tensions require to be taken into account in the medical and Mental Health Officer assessments. However, this need not be a gender-differentiated issue, in that this comprehensive type of assessment can also be made in relation to male service users, particularly who have children.

Barnes and Anderson Maple (1992) argue that family support may not be so available to women with mental health problems as it is to men with mental health problems. They are of the view that if a woman fills the supporting role of wife and mother, then, it may not be possible for role reversal to occur. This is also suggested by informant 12's view of women not being so able as men to go into hospital because of their caring responsibilities.

A gender based difference in decision-making could be regarded as discriminatory. Male Mental Health Officer 5's view will expand this consideration. He states:

...often if you are being asked to detain a woman especially under not so much an emergency section but you know like a section 26 [scope: 28 days detention], it's often because of concerns that they maybe have about 'well I have to leave the hospital because there will be no-one looking after the house or the children all day, I'll do this I'll do that', and these are things that can actually usually be worked round, whereas with men on section 26 it's 'I have to get out the hospital because I want to drink, smoke, take drugs' and those are things that cannot be negotiated really, so I probably consent more often to men being detained.

This male informant makes a gender-based difference in decision-making concerning detention. Childcare issues are considered with female service users though they are not considered with male service users. Different decisions are often reached by this Mental Health Officer between female and male service users. This could be regarded as discriminatory from the perspective that male service users are being detained partially on the grounds that they do not have childcare needs to meet, but on the other hand not detaining female service users on the basis of childcare concerns could be regarded as discriminatory on the basis that these service users may benefit from hospitalisation which they would probably receive in different circumstances. Underlying this view is the categorisation which links women to childcare.

The categorisation of 'women' and 'children', then, is a strong one in the views of some informants. It is often considered in terms of social roles, particularly that of



motherhood. This categorisation has sometimes been found to be assumed within mental health social work and can lead to gender-based differences in assessments and decision-making.

### *Women and Relationships*

The categorisation of 'women' and 'relationships' is found in the views of some informants. This is generally in the sense that women are more involved in relationships than men. Also, the perspectives of relationships are constructed in heterosexual terms by the informants.

Golombok and Fivush (1994) state that research has shown that females are stereotypically considered to be relational, that is concerned with social interaction, more than males who are stereotypically considered to be agentic.

Relationships, and particularly communications within relationships, are central to the psychological approach to mental health known as systemic frameworks (Dallos, 1996). Problems are viewed as residing not simply or predominantly in an individual but in the communications within relationships. If, then, mental health problems reside in relationship communications, and relationships are more central to women's lives than to men's lives, such problems may be more noticable in the lives of women.

Gilligan (1982) argues that relationships, and particularly issues of dependency, are experienced differently by women and men. She considers that masculinity is defined through separation – from the mother – while femininity is defined through attachment. Male gender identity is threatened by intimacy, then, whereas female gender identity is threatened by separation. Consequently, males tend to have difficulty with relationships, while females tend to have problems with

individuation. In this section, the views of several informants echo Gilligan's (1982) theory of gender-differentiation in terms of relationships.

Thompson (1995) also argues that males have difficulty with relationships. He states that masculinity can be seen as an impediment to personal relationships in that close relationships can be ideologically constructed as 'unmanly', incorporating, for instance, a fear of being considered homosexual. This suggests, then, a reason why relationships may not be central to men's lives. This construction of masculinity is based on withdrawing from or avoiding relationships, and a suggested motivation for this is fear.

MHO 11, female, suggests that women and men experience relationships differently:

I think my experience has been and it's not just really with MHO work...I think it's kind of across the board...is that men, sometimes there is a trigger when a particular relationship breaks down but in the main it's less to do with relationships with men than it is with women. Yes that's been my experience....[for men] it's things like behaviour, like drinking too much or being violent or not having a job and feeling bad about that, not succeeding with women, at work or with your peers, it's those kind of things.....[for women] a kind of repeated pattern of several relationships you know like repeating the same mistakes with the same kind of people, same sort of scenarios and never really learning from that and getting themselves back into the same set up again

Relationship breakdown is an issue in mental health work, and with men this female Mental Health Officer suggests that factors 'outside' the relationship contribute more to breakdown than with women. Women are regarded as more likely to repeat similar relationships even though they break down. The categorisation which is indicated is that of connecting 'women' and 'relationships', in the sense that women are embedded in relationships.

Female Mental Health Officer 2 also sees gender differences in relationships. She states:

MHO:....alot of the women I saw their mood was influenced was very influenced by the relationships they were in, just making them feel very deskilled, devalued, depressed, lacking in confidence and often really not I think all of these things are very kind of interlinked but often not giving themselves enough time or valuing themselves to say I need a bit of time to myself and how can I nurture me.

RM: Yes you talked about women so does that mean you haven't found that with men as much?

MHO: No not as much, well perhaps indirectly in a way because it was interesting the men who were referred to me were also referred because they were feeling depressed so but that was often that depression was seen to be linked to being made redundant, being out of work, being unemployed although I think that too had an impact on relationships that they were in. The men tended to focus on feeling loss of confidence as a result of being made unemployed.....what they were saying was partners didn't understand or they weren't you know very caught up in what was happening to them and not paying enough attention to the partner not giving enough time which obviously had an impact on the relationship.

Both women and men can become depressed as a result of relationships, in this view, though for different reasons. For instance, as with female MHO 11, female informant 2 sees the factors influencing male mental health as mostly 'outside' the relationship, whereas she sees the factors influencing female mental health as mostly 'inside' the relationship.

Male informant 9 sees gender differences in relationships. He states:

I mean it's just a generalised perception that may be wrong, may be women there is a component breakdown in the relationship...seems to be more common with women than with men because there seems to be a more adverse reaction to relationship breakdown as a factor in mental health presentation. I may be wrong I don't know, it's just a generalised perception.....Men maybe don't it's not so obvious, they bury it, if the feeling is there they repress it, with women I think it's more obvious I am not saying it's different but it's more obvious.

This informant is cautious in presenting his view of gender differences in relationships, for instance, he twice states that he may be wrong. Both women and

men are involved in relationships, according to this view, but women are more overtly emotionally involved than men. Male Mental Health Officer 9 links this to mental health in the sense that a relationship breakdown can affect the mental health of women more than men. He suggests that relationship breakdown means different things to women and to men.

Female Mental Health Officer 12 relates a greater involvement in relationships by women to gender roles:

I think women think more about their relationships with people and they hurt more and they are hurt more....Men can behave badly and their behaviour is put up with by women who are caught in the house because they have got children, because they are emotionally attached to the man and because they are economically not as independent. Men can move on move out.

According to this informant, women generally are more emotionally involved in relationships than men, but this has various negative aspects to it, such as less independence in economical terms. Mental Health Officer 12 relates the negative aspects in heterosexual relationships to the different positions or roles which women and men tend to occupy, for instance, the care of children as a female role and economic provision as a male role. Also, this informant highlights a greater emotional attachment on the part of women compared to men, which is placed in the context of different roles. The female role is constituted in terms of caring or looking after others.

Underlying these perspectives is a typification of 'women' and 'relationships', whereby women are considered as more emotionally involved than men. The linked suggestion is that the mental health of women is more closely tied to relationships than is that of men. The processes of categorisation of 'women' and 'men' in relationships have highlighted a gender difference. Women are considered as more embedded in relationships or more caring than men. An Equal Opportunities Commission research study and an influential article by Finch and Groves, both in the 1980s, drew attention to the fact that caring is mainly carried out

by women (Cree, 2000). Recent research on caring has noted that though women make a significant contribution to caring, it is not solely a woman's experience (Cree, 2000). The caring, or relational, aspect of men's lives is not considered by informants in this section. This in itself suggests that the informants do not associate caring as an aspect of men's lives in the regular way that it is often related to women's lives. Such a different view of what is expected of women and men could lead to gender-differentiated judgements by Mental Health Officers.

Gender-differentiated concepts of behaviour, and specifically in terms of relationships, suggest different expectations of female and male service users on the part of Mental Health Officers. For example, a female service user who seeks a lot of social independence may be regarded by MHOs as more unusual, and perhaps more problematic, than a male service user who seeks a lot of social independence. This could lead to differences in mental health assessments and decision-making.

### Women and Depression

The categorisation of 'women' and 'depression' is found in various informants' perspectives. These are presented initially in terms of groupings, that is, female informants' views and male informants' views.

Female informants state:

I mean if you are talking about people who get depressed in their lives, and are still ill but they get depressed and they get better, then I think you have got more chance of that happening to you if you are a woman because you have children so you can get depressed after you have children. [Mental Health Officer 12]

It is an area I have always been very interested in is women and depression and I mean I don't know what research says but just in a very kind of general way I would say that in my experience I do come across or have come across more women with a depressive illness than men. [Mental Health Officer 2]

I've not met that many people, many men, with depression. A couple with mania but not with depression, at least that isn't the presenting...whereas I think that is the opposite with women. [Mental Health Officer 3]

...generally speaking in psychiatric hospitals there is more women in with depression than there is men. [Mental Health Officer 7]

Male informants state:

...in terms of woman's mental health problems, if they have come from a sort of abusive relationship then mental health problems might present in the form of a depressive type illness. Men can...get depressed as well, but perhaps women are more prone to it. [Mental Health Officer 20]

Again I have just a generalised perception not research basis but more obvious depression, it's a dreadful sexist thing to say, but more obvious depressive presentations with women and I don't mean to be sexist it just is ...the way it is. [Mental Health Officer 9]

Each of these female and male informants places the term 'depression' in association with the category 'women'. Male informant 20 connects female depression to relationships, specifically abusive ones. Female informant 12 relates female depression to childbirth. There are, then, different contexts given by these informants connecting 'women' and 'depression'.

Ussher (1991) states that various surveys have shown that women are more likely to report psychological distress, particularly depression, than men.

A specifically female form of depression is postnatal depression. The World Health Organisation (1994) states that postnatal depression has been observed in various cultures. It also reports that depression is the mental health problem most often found in many developed countries among women, and that depression increases with the number of children. This, then, supports the general connection of 'women' and 'depression', as well as the specific connection of 'women' and 'postnatal depression'.



Mauthner (1994) views postnatal depression in terms of interrelationships between an active self, others and society. She suggests that postnatal depression is characterised by, and results from, a psychological process of relational disconnection in which mothers feel alienated from themselves and others. This is a process in which mothers actively withdraw their needs and feelings from relationships with others in order to conform to a cultural ethic of individuality and self-sufficiency. Postnatal depression is a specifically female mental health problem.

A further two male Mental Health Officers, 17 and 18, place the connection of 'women' and 'depression' in terms of their knowledge of research, as follows:

...within what little research I've done on the course or in social work just reading generally, I've always had the notion the reality that women in certain situations are more likely to be prone to depression to depressive illnesses, you know the old research I should imagine it still stands about particularly if you are isolated, you have a number of young children, unsupportive partners..... that strikes me as true. [Mental Health Officer 17]

Well does research not show that women are diagnosed as having depression more often than men? [Mental Health Officer 18]

Both of these male Mental Health Officers use research as a basis on which to place the connection. Informant 18 talks in general terms about the groups 'women' and 'men', whereas MHO 17 specifies circumstances which make women more 'prone' to depression. Both, however, hold to linking 'women' and 'depression' more than 'men' and 'depression'.

Two other male informants, 13 and 16, however, state that they are not certain of the connection between 'female' and 'depression':

...more women present to primary care with symptoms of depression than men, there is less of men but higher suicides because if men aren't going to the doctor but are seriously depressed by not doing that there is a higher



fatality so I think maybe there aren't gender issues, there are issues when you look at paperwork and they say 'well yes there are two thirds as many women as men suffer from depression'. I am not I suppose I am not convinced that is the case. [Mental Health Officer 13]

Women are more likely to be sectioned and detained or prescribed for depression than men which is not necessarily to say that they suffer more from it, it is just that they tend to go down the medication route and possibly end up in the hospital route quicker. [Mental Health Officer 16]

Both of these male Mental Health Officers are sceptical of the view that more women than men experience depression. Instead, Mental Health Officer 13 considers the possibility that men who are depressed may not necessarily present to the health care system, and Mental Health Officer 16 suggests that women enter the system sooner than men.

Male informant 13 relates his perspective to the context of experience, as follows:

I think we all humans suffer the dreaded depression to life events.

He also considers middle age as a time of crisis for men and of possible middle-aged male depression. This Mental Health Officer, then, connects the term 'depression' with the category 'male', specifically 'middle-aged male'. He also considers his perspective towards depression in terms of personal experience, which is exemplified through the use of the term 'we' in 'we all humans'. These considerations lead him to question the categorisation of 'female' with 'depression'.

Male informant 16 places his view in the context of questioning some decisions by medical colleagues. For instance, he gives an example from his experience as a Mental Health Officer of an 18 year old woman who could be suffering from depression or having a reaction to a termination she had gone through. This Mental Health Officer implies the possibility of misdiagnosis of depression by medical colleagues, and states in general terms:

I would take into consideration...reasons as to why a woman may be more susceptible to either suffer from mental illness or being diagnosed as suffering from mental illness, either quicker or misdiagnosed or medicated or being put on medication quicker...

Informant 16, then, has a critical view of the medical perspective particularly in terms of gender. He considers that the medical perspective is at times a gendered one, that is, it differentiates between the group 'women' and the group 'men' as patients. The categorisation of 'female' and 'depression', and the wider categorisation of 'female' and 'mental health problems', is one that this informant consciously questions as it does not fully relate to his experience as a Mental Health Officer. There is a fracture, then, between typification and experience in his view.

Instead of accepting the typification that depression affects more women than men, these two male informants, 13 and 16, draw on their experience to question this. The categorisation does not satisfactorily apply meaning to all relevant situations for them. Awareness of such a gap leads to further questioning of the categories and their relation to experience, opening up other possibilities of explanation, such as misdiagnosis.

Busfield (1996) states that a number of studies have found no significant differences between women and men from some social groups in the symptoms of depression reported. This supports the view of questioning the categorisation - 'women' and 'depression'. She also argues that the meaning of the concept of depression has changed markedly over time, for instance, it initially entered psychiatric classifications as a symptom of melancholia.

There is evidence, then, of the typification 'women' and 'depression' within some Mental Health Officer views, and also of questioning the typification in others. This could influence assessments of mental health and decision-making, for example, a Mental Health Officer who is doubtful of a diagnosis, such as depression, may be less willing to input resources to that case.

## Men

The categorisations which are found in the views of some informants concerning 'men' will be studied in this section. These are 'Men and Aggression'; 'Men and a Reluctance to Talk'; 'Men and Discrimination'.

### Men and Aggression

The belief in male service user aggression is found in the views of various informants. These are presented in terms of groupings, that is male informants' views and female informants' views.

Male informants state:

...young macho man, both young men...fighting the diagnosis of their symptoms the only way that they have to manage that which is by sort of traditional male aggression, in other words rage, anger and that very masculine bit...and I think both have very very strange and threatening attitudes to women....trying to make sense and fight and you know like be normal. [Mental Health Officer 13]

I possibly do find it easier to work with women....maybe there is not that same risk or you haven't got that idea there could be a violent outburst here that you couldn't manage. [Mental Health Officer 15]

I think I would probably be more looking for a danger to others from men than I would be from women. [Mental Health Officer 5]

I think you may be thought to be more violent because you are a man. [Mental Health Officer 16]

I was thinking that when large strong men are detained people often talk about that and they say 'he is a big guy watch him he is potentially going to be violent'; if he is violent you know you need to manage that situation but people don't say that often about women. [Mental Health Officer 17]

Female informants state:

I suppose if a man had a criminal record, for example, for rape or something then that might I suppose that might affect the way I would work with him....you could say any violent crime like murder. [Mental Health Officer 6]

...at the IPCU [Intensive Psychiatric Care Unit]...it's just the atmosphere of the place and that there is lots of men pacing up and down...the atmosphere is definitely heavier and you know it's more threatening. [Mental Health Officer 3]

...there are folk that get sort of labelled he is misogynistic, he is a real woman hater, impossible for any woman to work with... [Mental Health Officer 10]

My experience has been that men can use their strength to overpower women. [Mental Health Officer 11]

I am...thinking about male service users male patients who have had a history of violence....I have made my own decision about my personal safety. [Mental Health Officer 14]

The categorisation of 'men' and 'aggression', in the views of these female and male informants, is sometimes a general one concerning the whole group 'men' and sometimes it is specific to male service users. The notions that men are physically stronger than women, and that there is more danger to others from men than women, are put forward by various Mental Health Officers.

The risk of male violence in relation to women is sometimes considered from a sexual point of view. Female informant 6 specifically mentions rape as a possibility of male violence. Female informant 4 mentions sexist personal comments from a male service user that she has worked with.

Chesler (1996) points out that studies of childhood behaviour problems have indicated that boys are most often referred to child guidance clinics for aggressive and destructive behaviour. Girls, on the other hand, are mostly referred for personality problems, such as excessive fears and worries. Chesler (1996) further states that similar sex-typed symptoms exist in adults also, and that the symptoms of men are more likely to reflect destructive hostility towards others whereas the symptoms of women express harsh self-criticism. This suggests that there is a link of 'male' and 'aggression', which is associated with behavioural problems, in male childhood and also adulthood.

Thompson (1995) argues that, although some women do indulge in violence, aggression and violence are predominantly masculine phenomena. He considers that a significantly higher proportion of men exhibit violent tendencies than women, and that commentators who bemoan the levels of violence in society rarely acknowledge the strong association between masculinity and violence. Miller and Bell (1996), however, point out that men are at one and the same time both damaged and damage-doing. It is the agency of masculinity, they argue, which damages men and also predisposes them to dominate.

Female informant 11, based on her experience, considers that men are physically stronger than women and that men are more able to overpower women. This suggests a biological orientation which, in relation to gender differences, is sometimes associated with assumptions of female biological inferiority (Busfield, 1996).

Female Mental Health Officer 11's work with male service users is affected by her view that men are more able to overpower women, in that this potential power of men has prevented her from 'confronting an issue or from doing a visit'. No such avoidance is seen as necessary in her work with female service users. She talks in terms of gender categories, for example, '...men can use their strength to overpower women'.

Some informants, however, question the basis of categorising 'men' and 'aggression', for instance, male Mental Health Officer 16 does not take the categorisation as read and female Mental Health Officer 3 questions whether the male service users do exhibit violence towards the female workers.

Male informant 17 believes that large men are generally stronger than women and so more able to be effectively aggressive but considers that this is also evidence of some stereotypical thinking.

Featherstone (1997) states that the link between violence and power is ill conceived, arguing that men's violence could be read as evidence of their growing powerlessness as much as of their power. She further states that postmodernism and poststructuralism have led to a growing recognition that women's and men's subjectivities are not stable, essential or fixed. She argues that the notion of woman as victim, or of her occupying any one fixed position, is no longer acceptable to many. This suggests an opposing view to the fixed position of categorising men as stronger than women and so able to overpower women.

Female informant 3 presents a problematic relation between categorisation and experience. She has experienced a threatening atmosphere in a locked ward of mainly men. She regards the atmosphere as a male threat, yet she has never been threatened by any man there. Informant 3 has been assaulted once and that was by a woman. Despite this latter experience, she felt the atmosphere threatening in the locked ward because of the men present. This suggests that there is a fracture between typification and experience in this instance. That is, despite the experience of being assaulted by a woman, female MHO 3 holds to the typification of 'male' and 'aggression'.

Male informant 15 has not experienced violence from a man or a woman, though he anticipates violence to be a greater risk from male service users and this results in



him being more relaxed with female service users. As with female informant 3's view, male informant 15's view indicates a fracture between categorisation and experience.

Male informant 5, in assessing a service user for possible detention, makes a distinction between women and men in that he considers there to be a greater risk of danger to others from men. He also, however, states that this may be 'wrong', suggesting that he is uncertain of the basis of this knowledge. The informant's categorisation of 'men' and 'danger', suggesting 'aggression', is one which he questions on an experiential basis as possibly being 'wrong'. Stanley and Wise (1993) argue that this is indicative of a slip between categorisation and experience, which can result when category expectations meet everyday behaviour.

Another male informant, 16, regards the perception of men with mental health problems as more violent than women with mental health problems to be not simply inaccurate but discriminatory. Burns (1992) argues that men who are detained under Mental Health legislation tend to be kept in more restrictive settings than women on the grounds that society deserves much greater protection from men. This suggests possible discrimination against the group 'men with mental health problems' because of assumed aggression and violence from which society needs to be protected.

There is a differentiation regarding aggression between the groups of 'women' and 'men' in various informants' views. This differentiation has tended to take the form of: women – victims of male aggression; men – aggressors. An aggressive capacity is usually identified with male service users or the group 'men' rather than with male workers. The category 'male' is fragmented between male workers and male service users in the context of work between Mental Health Officers and service users. Victims, or potential victims, however are usually associated with the category 'female' whether female worker or female service user.



Despite variable experiences, the belief in male violence is often held to by these informants. This belief raises the problem of gender-differentiated mental health social work practice, such as a Mental Health Officer not visiting a potentially violent male service user because of risk concerns.

### *Men and a Reluctance to Talk*

The categorisation of 'men' and 'reluctance to talk' is raised by various informants, usually in conjunction with the categorisation of 'women' and 'finding it easy to talk'.

The categorisation of 'men' and 'reluctance to talk' is fairly strong and mostly placed in the context of the whole group of men. It is then sometimes related specifically to mental health issues. A few Mental Health Officers consider this typification as possible stereotyping, and some place it in terms of their own experience. The male Mental Health Officers in this section generally gave more in-depth perspectives than the female Mental Health Officers.

Thompson (1995) puts forward the view that there are gender differences in conversational styles and that these are related to different orientations. Men, it is argued, are primarily oriented to achieving status whereas women are primarily oriented to 'connectedness', that is, to personal relationships. This suggests a link between women and communication or 'talk', particularly within personal relationships. Such a gender-differentiated view is constructed in the binary terms of 'women' and 'men', and does not tend to focus on differences within the groups.

Female informant 2 gives the following example highlighting the difficulty a male relative experiences in talking of a mental health problem he is experiencing:

...a male member of my family has had to go and see the doctor because he was feeling depressed .....but I think in the first place was very reticent about going to the doctor because he felt as the sort of male within the family it was somehow to be frowned upon to have to admit that you were feeling depressed and not coping ..... I certainly feel that men have more difficulty with that than women have and so that raised...an issue for me about you know the male kind of thinking about depression, their self-image, seeing themselves as the...providers, and shouldn't for some reason become depressed and that is something that females get but not men...

This female Mental Health Officer, from this example, generalises to why it may be difficult for men to talk about worries. She considers that the perspective of her male relative towards talking about feeling depressed is that this would be an admission of failure. The failure is in 'not coping', particularly in his perceived role as provider. This suggests a perspective which is constructed in divisional terms of female and male roles, whereby the male role is that of provider. Success or failure are indicated in terms of how the role is fulfilled. Present day roles, however, tend to be more complex, for instance, both women and men can be providers and both can be carers.

This informant also suggests that men regard depression as a mental health problem of women. The theoretical literature focusses on depression as a problem of women (Ussher, 1991). Therefore, depression tends to be defined as more of a female mental health problem which could lead to considering a man with this 'female' problem in terms of failure.

Female MHO 11 also considers that men do not tend to talk about their worries:

I don't think men tend to talk about them, what is worrying them, they tend to bottle it in a way that I don't think women do quite as much so that when it blows it blows, there is whole lot of stuff in there that has been saved up for probably years.

This informant presents her view in terms of the gender groupings. MHO 3, female, states that women tend to talk about their worries:

I think women I mean it's just the fact women talk, I mean I have friends who...and I myself have thought 'crikey you are teetering on the edge of not feeling great about life or whatever' and you are thinking 'my goodness', and my friends and I we talk about it and I think only women do that you know, do openly and I think it makes it easier...

The informant's experience of when she has worries is that these are discussed with female friends to alleviate them.

Female Mental Health Officer 12 considers that there are gender differences in discussing worries:

I think with a few exceptions I would always rather discuss things myself with a woman because I think women are naturally more inclined to discuss things that are still painful to discuss but they do discuss them. I think men, it's a huge generalisation, I think men in general are more likely not to discuss painful things and keep them to themselves, and I think that without getting into why I think that, I think that that is so inbuilt in us that I don't find it difficult to discuss painful issues with service users because I do it myself in my own life.

Again, this informant considers that in relation to painful issues or worries, men in general will not discuss these to the same extent that women will. She emphasises that the view is a generalised one, indicating an awareness of typification. Her preference is to talk with another woman, however, there are some exceptions. The inclusion of exceptions indicates that her experience is that there are some men who are willing to discuss 'painful' issues. There is, then, a gap between typification and experience, and this Mental Health Officer's perspective highlights it in terms of exceptions.

Stereotyping is considered by some of the Mental Health Officers as underlying their perspective of men having a reluctance to talk in comparison to women. This suggests that these informants consider their views to be typified. Kramarae and Treichler (1992) put forward the stronger argument relating to women finding it easy to talk, and based on research findings, that the perspective of women as talkative is a myth.

Stereotyping is indicated in the view of female informant 4:

I think there are probably a lot of women who have experiences of stress and depression in quite a severe form because of personal difficulties or dealing with problems. I suspect that men have similar difficulties but different or perhaps less able to give expression to that....more assumptions.

This informant suggests that men may be less able than women to talk about experiences of mental health problems, such as depression. The phrase at the end 'more assumptions' indicates some uncertainty as to the basis of her statement. This phrase suggests that stereotyping may underlie her view.

Female informant 10 also brings in stereotyping to the connection that men have difficulty in talking about problems:

I mean there is the stereotypical thing about well men are less likely to talk about how they feel I mean I think that is around and that is maybe more around for maybe men of an older generation. I actually find that you know a lot of the people we see...when we are on MHO duty are younger people.....and I think men are probably getting better at talking about how they feel so I am not sure that that is you know that that is such a big deal.

This Mental Health Officer indicates that the connection of men having difficulty in talking about problems is stereotypical but that it applies particularly to older men. She suggests that men, particularly younger men, are more able to talk than they used to be. The indication of stereotyping seems to lead this informant to examine the categorisation from a different perspective and she does so by looking at the issue of age and the process of change.

If 'fixed' is taken as inherent to the meaning of 'stereotype' as in fixed or unchanging ideas about individuals, groups or objects, then, Mental Health Officer 10 is challenging this. She sees the development of changes in the connection of

'men' and 'talking' when she states '...men are probably getting better at talking...'.

Male informant 18 considers that men can learn to talk and I, as interviewer, agree with that by stating:

Some men are very open to talking I have found...so you have these rules or stereotypes in your head and people can be so different you know you are sort of balancing your experience against stereotypes.

It is only in relation to my experience, as part of the context of discussion within the interview, that I state that the categorisation does not apply meaning to every relevant situation. I have known men who, as I say, seem to be open to talking and simply do not 'fit' the typification. This gap or fracture opens up the relation of categorisation and experience.

Alcohol or drug taking is highlighted by three male informants – 16, 17 and 18 – as ways in which men attempt to cope with their worries rather than to talk about them.

Busfield (1996) cites a broad claim to be found in Western culture that women and men respond to psychological difficulties in different ways. Women typically internalise their feelings whereas men turn them outwards into, for instance, excessive drinking. The views of the following three male Mental Health Officers indicate agreement with this claim, particularly concerning the behaviour of men.

Male informant 17 states:

...men don't, I don't want to be sexist about this, I think that men haven't talked about some of the areas about feelings and expressed them, or what is your concerns and your difficulties with other people, and to that extent [men] don't do that as often personally as some women not all women and not all men, .....I think that certainly that it is probably true to say that women will often just in life in general would be more open to discussions as I say around feelings, emotions, personal problems, personal worries

whereas men would in whatever way would often cover that up or try and diminish it or redirect their energies or whatever else it might be...I think as a consequence of that a lot of men ....try and cope with it in other ways through alcohol use, drug use, football you name it there could be a whole range of things that somehow act to support them in their lives, a prop in their lives which women would use in different ways...

In stating that his view does not apply to the entire group 'women' and the entire group 'men', this Mental Health Officer indicates that he is aware of possible categorisation and that there are exceptions. He does, however, state that 'a lot of men' use props such as alcohol or drugs rather than talking through their worries or problems with someone else.

New (2001) states that a feature of men's oppression concerns mental health, such as men's greater use of numbing and comforting drugs. She argues that alcohol and other drugs function to keep men enduring aspects of their lives which are distressing to them.

Mental Health Officer 18 similarly highlights male alcohol and drug intake:

...they [women] share their if you like distress ...by talking about it to other people and they gain some support and help from that but they also gain a label.....men women respond differently to their sadness or depression and women tend I think to talk more and men tend to talk less and find other sorts of distraction like self isolation in the form of the activities that they undertake or taking to drink traditionally, certainly in the Scottish culture, and drugs...

This view is presented within the context of the whole group of women and the whole group of men, in relation to mental health issues, such as depression and 'sadness'. Although his view indicates that there is a need for men to talk, he also suggests such talking may not produce entirely beneficial consequences. He states that women talk about their worries to others and they get support from that. However, they may also be labelled. This suggests negative connotations, such as associated stigma.

Thompson (1995) suggests that men are more reluctant than women to seek help. Russo (1984) states that women report more emotional problems than men and seek psychiatric help at a higher rate than men with comparable emotional problems. These arguments are echoed in the view of informant 18 in relation to women talking to others regarding 'distress'.

Male informant 18 also regards taking alcohol or drugs as a substitute for talking in the case of men. He specifically mentions the influence of culture, in that the Scottish culture traditionally makes a connection between alcohol and the category 'men'. This cultural context is historically-based as well as present day.

Mental Health Officer 16, male, states regarding 'men' and alcohol or drugs:

I would say in general men find it, and it is a generalisation, men find it more difficult to talk about how they are feeling and tend to use actions rather than talk about it, cover it with alcohol or drugs...tend to use that as a 'blocker-outer' of how they are feeling although yes in general it doesn't mean to say the women don't use these things as well .....I would say men find it more difficult to talk about either what they are experiencing or what they have experienced on a recovery road which I think then tends to feed into you are more likely to have it again more quickly and maybe with worse consequences...

This informant presents his view of men having difficulty in talking as a 'generalisation', indicating that there is a sense of categorisation. Similarly to male Mental Health Officer 18, he highlights that men tend to use alcohol or drugs in order to ignore what they find it problematic to talk about, that is, feelings. In relation specifically to men who have experienced mental health problems, this Mental Health Officer states that such a difficulty in talking makes overcoming the problems less likely to be successful. His view, then, suggests that being able and willing to talk means recovery from mental health problems is more likely. Such talking is regarded by him as beneficial in relation to mental health issues whereas informant 18 considers that it could bring its own problems, such as labelling.



The categorisation, then, that men have more difficulty than women in talking about worries and problems is found within the views of various informants, both female and male. This is sometimes related specifically to mental health issues, such as whether talking is a benefit to mental health or not. Also, 'men not talking as much as women' is sometimes connected to male-intake of alcohol and drugs. There is also a suggestion of stereotyping from several Mental Health Officers regarding the typification.

The categorisation indicates that these Mental Health Officers sometimes hold to differentiated behavioural expectations in relation to women and men, specifically female and male service users. This could lead to gender-differentiated assessments and decision-making in the role of Mental Health Officer. For instance, a MHO may assess differently, perhaps more severely, a woman who is unwilling to talk compared to a man who is unwilling to talk because this does not follow typification.

### *Men and Discrimination*

The possibility of discrimination against men is revealed in female Mental Health Officer 7's view:

I think men have enormous work to do on their own mental health problems...I am laughing now because I know one person that went to a men's group and gave a description of it and I was in absolute stitches, you know it was the real alternative crew that probably had read every feminist book on the bookshelf and were trying to be real men or new men or modern men or whatever they are supposed to be, so yes I do think men have a lot to learn on their own health mental health.

This female informant sees a gap in male self-knowledge of mental health issues. The perspective of Mental Health Officer 7 also raises a problem of discrimination which is specific to men, in that in attempting to broaden knowledge based on male

experience, men can be regarded in stereotypical terms as doing something almost feminine. That is, in talking and communicating concerning male experience, men could be discriminated against, such as, not being listened to. For instance, female Mental Health Officer 7 states that she found a description of a men's group humourous, which could be a way of not hearing. The phrase 'were trying to be real men or new men or modern men or whatever they are supposed to be' could be regarded as discriminatory in that it encapsulates the idea of change but does not seem very open to it.

Thompson (1995) argues, as stated earlier, that close relationships can be ideologically constructed as 'unmanly' and that there are factors, such as fear of being thought homosexual, which act as barriers to men enjoying such relationships. This type of construction is suggested by the view of informant 7, in that it is an example of men attempting to become close and have discussions with each other, which she does not seem open to.

The topic of 'men' and 'discrimination', is also raised by some informants in the sense of men suffering from discrimination.

Female informant 11 states:

...people have stereotypical views of men and what they need and what how they are. I think men are different from women, I think they think differently from women, I think they process things differently from women, and therefore...there should be positive discrimination.

This female Mental Health Officer considers that views of men and their needs are often stereotypical. This suggests typified views rather than, for instance, the inclusion of varying and different perspectives towards male needs. Mac An Ghaill (1996) theorises masculinity as problematic, negotiated and contested, and not as a monolithic perspective of men and masculinity. He states that there has been a shift to notions of multiple masculinities. This shift is not noticeable in stereotypical views of men.

Female informant 11 considers the gender groupings as distinct from each other, stating that 'women' are different from 'men', that this should be taken account of in mental health social work and could result in positive discrimination concerning men. To state that men 'process things differently from women' suggests a view based on 'natural' or 'essential' difference, such as biology. Arguments based on biological difference indicate notions of fixed positions and this has already been critiqued.

Male MHO 15 considers that men suffer discrimination as well as women:

I think it has been all too easy just to say gender discrimination means discrimination against women you know because of power imbalances or whatever but I think that is not the case because I think equally men are pigeon-holed and pressures put on them in certain aspects as well that it is felt to be discriminatory, and I think that it does apply whether it is in equal measure I am not sure...

This male informant's perspective holds that gender discrimination is considered mostly in terms of women, whereas there are also areas of discrimination which men experience. The Male Link research project (2000) found that of 632 men interviewed, two thirds believed that men are discriminated against on the basis of their sex. Cavanagh and Lewis (1996) argue that men, as well as women, are disadvantaged by patriarchy, though the oppression of women in a patriarchal system is greater.

New (2001) argues that men are systematically mistreated as well as women. She considers that the institutional positioning of men through the division of labour in employment, in the family, and as citizens, is central to understanding their place in power relations and why they are both oppressors and oppressed. New (2001) argues, then, that men (as well as women) experience discrimination.

Male informant 15 also gives an example of a male discriminatory issue:

...certainly it does apply that there is a discriminatory aspect to the treatment that men get, they may be getting too much help, I mean it may be I suppose just...if a man is unwell on their own then I think that they [men] are probably more likely to get help than a woman that is on her own...unless they [women] can clearly demonstrate that they are frail and disabled as well, not necessarily in mental health things. I mean I am sure if we saw an old man and old woman exactly the same situation, exactly the same physical problems, there is probably a fair chance that the man would get...the assumption would be that the man has never had to do this before so therefore he needs more help. I don't see how that doesn't filter down into mental health stuff as well.

This view identifies an aspect of the social work service towards a male service user as discriminatory, in that he probably gets much more help than a female service user in similar circumstances would receive. It could be argued instead that the female service user is being discriminated against if she is not receiving as much social work help as the male service user. However, male Mental Health Officer 15 makes the point that the man might receive too much help. This suggests that he is being considered in child-like terms of not being able to manage as well as a woman, and that this is the discrimination the informant highlights. However, there may be different understandings of what constitutes discrimination in a particular case.

Male informant 5 takes a different perspective towards discrimination which men may experience. He states:

...it feels kind of you know assessing things from a gender perspective for men... but 'hang on' they have got lots of the advantages anyway, so maybe what I am saying is I don't, even speaking as a man, know enough about what the particular pressures are on men that will lead to mental health difficulties.

This male informant does not equate the positions of women and men in terms of discrimination since he states that the latter have 'lots of advantages'. This leads Mental Health Officer 5 to identify a gap in knowledge concerning male mental health problems. Ramsay et al. (1996) also highlight a gap in knowledge of male

mental health problems. They argue that mental health professionals need to direct attention to men's mental health problems which they may currently be missing.

Cavanagh and Lewis (1996) similarly argue that not enough is known of 'men', and specifically of men's mental health problems. They state that research needs to be carried out on men, not only women as feminists have tended to do.

Therefore, several informants' views focus on discrimination against men on the basis of gender. This is sometimes related to the whole group of men, and sometimes it is specified to men who experience mental health problems. It has also been suggested that men do not experience as much discrimination as women on the basis of gender. However, the view of some Mental Health Officers that there is discrimination against men, and particularly men who experience mental health problems, suggests that there may be gender-differentiated practice against male service users in mental health social work.

### *Women, Men and Vulnerability*

The categorisation of 'female' with 'vulnerability' and 'male' with 'lack of vulnerability' is found in some informants' views towards the topic of safety in mental health social work. Variations to this categorisation are also found in informants' views.

This section presents, firstly, same-gender working relations and, secondly, across-gender working relations.

#### *A] Same-Gender Working Relations*

Some informants raise the subject of male workers being expected to work with male service users at times because of safety reasons, such as, the protection of

female staff. Their views are differentiated as to whether such a suggestion is acceptable or not.

Phillips (2001) states that in mental health social work services, it tends to be men who are expected (by managers and by some women colleagues) to take a lead in dealing with actual or potential violence originated by a small number of service users. He is not suggesting that it is inappropriate for men to take the lead in these situations, but that male practitioners need to beware of reinforcing gender stereotypes in the provision of services to people who have mental health problems.

Overall, the views in this section suggest some gender stereotyping. Golombok and Fivush (1994) argue that stereotypes represent culturally shared beliefs. As stated previously, they consider gender stereotyping to hold that females are relational whereas males are agentive or instrumental. This type of stereotyping seems to regard men in a more active sense than women and this is echoed in the view of some informants that male workers should (act to) protect female workers. However, stereotyping is rejected by some Mental Health Officers.

Some male workers are keen to carry out the protective role, for instance, male Mental Health Officer 20 states that he has worked with several male service users where it has been assessed as inappropriate for various reasons for a female worker to work with them:

...there are other examples of my involvement particularly with men where for various reasons I think it seems appropriate that it is a male worker as opposed to a female worker...because they [female workers] are sort of vulnerable...

In this case, then, same-gender working relations are considered appropriate, and vulnerability is related to the female workers in alignment with the categorisation.



Male informant 1 finds it relatively unproblematic to take over in the following situation:

I picked that case up from [female worker]... and the reason I am working with him now is because his previous MHO was a woman and was really uncomfortable in working with him. In fairness to her she was working with him at a time when he was much more ill and there was that kind of pathological edge to what he was doing and she didn't feel safe and...I don't have a problem with things like that, I don't think you should stick to principles and make people work with people...regardless of these kinds of issues. I think it's perfectly acceptable if somebody is going to get on better and be better supported by someone either because they are a man or a woman, I think that is fair enough.

The suggestion of aggression from the male service user results in the female Mental Health Officer not feeling safe in working with him. In this situation male informant 1 is substituted for her in order that she can stop working with the perceived risk. The underlying assumption, which this informant goes on to suggest, is that as a male Mental Health Officer he will be more able to work safely with this male service user. This perspective constructs the female worker as needing protection and the male worker as providing that protection through substitution. This categorising divides 'female' and 'male' in terms of vulnerability. There is in this instance, then, differentiation between the group 'women' and the group 'men'.

There is also, however, differentiation between 'men', specifically the male worker and the male service user. Christie (2001) argues, as stated previously, that in contemporary discourses of welfare, men are represented paradoxically as both sources of risk and offering the potential to reduce risk within families and communities. This paradox is demonstrated in the above example, in that the male service user is assumed to be a source of risk and the male worker is assumed to offer the potential to reduce risk. These are power relations whereby the worker is viewed as having the power to control the service user's assumed aggression. The



male gender, then, is differentiated in terms of risk within the context of the Mental Health Officer and the service user interaction.

The expectation that male workers should deal with situations of potential violence is considered by female Mental Health Officer 8 to be discriminatory. She states:

I have come across the situation where there is a potentially...violent service user needing visiting...and the male manager at the time insisted on sending the biggest male worker, which was very interesting at the time. This wasn't a MHO case it was just a visit I had done, it is interesting...to me, that was discriminating against that male worker wholeheartedly.

Female Mental Health Officer 8 is clear in her view that this is a situation of discrimination towards the male worker. Therefore not all female social workers expect male workers to carry out such work. Although the male worker in the example is not a Mental Health Officer, this informant puts forward the example as of related relevance since it concerns a social work situation.

Several male informants do not take on the protective role willingly and even react against it. Male Mental Health Officer 16 states:

You do tend to get ...through allocation tend to get the difficult possibly potentially violent men who have mental health problems. I think there is a bit of that, I suppose when I first started I used to say well that needn't necessarily be me that was before [male name] was here and I was the only man in the team so you tend to get those referrals. I try and say no just because you are a man working with a man doesn't mean to say that violence is less likely to happen, it might be more likely to happen and if that was the case then there should be two of you working with somebody if they are potentially violent anyway.....We then started going out we were in twos initially if there were concerns from the referral or from somebody having known somebody feeling that...they might be violent, just a bit uneasy, sometimes it is not as overt as...they are a violent person with a history of violence they just felt uneasy in their presence sort of thing so you get called along as a shotgun, which is fine because you are just the other person, if that is what is needed that is what is needed. Yes there is that with being a male worker as well as a MHO I suppose.

This informant highlights the expectation made of him by colleagues to take up work that may be of a violent nature and specifically with male service users.

Cree (1996) points out that male social workers sometimes experience pressure to adhere to traditional views of masculine behaviour. For instance, in residential care settings, they were sometimes expected to be involved in physical restraint.

Similarly, this male Mental Health Officer experiences pressure when he is expected to work with potentially violent male service users. He gives several reasons why such work need not be carried out by him, such as being a male worker does not mean that violence from male service users with mental health problems is less likely to occur, and might be more likely to occur. This informant is aware of personal vulnerability. Mental Health Officer 16 is not at ease with this expectation which is placed on him. The expectation assumes a different relation between male service users and male workers, compared to female workers. This informant, though, is not in agreement with the reasoning behind the expectation, and he struggles with the peer pressure. He suggests that in circumstances where violence is considered to be a risk, two workers should jointly carry out the work.

Male informant 5 is strongly opposed to the suggestion that male workers should work with male service users at times because of safety reasons. He states:

The chauvinist type thing I suppose is that as a Mental Health Officer especially in emergency assessment sometimes you are going into situations which you know you don't actually know what is waiting for you behind the door and you don't actually know how agitated, bad-tempered or potentially violent somebody is and there is still overall...maybe [informant] won't mind so much because he is a man. I'm here to tell you [informant] minds a whole hell of a lot, so that can be a disadvantage and there can still be a bit of a..you know having to say sometimes 'well I won't go with somebody', less so I think as the years have gone by. When I first worked at Dingleton if I was saying 'well I don't really want to travel to this council house in the middle of the night to meet up with the GP to possibly do a section 24 on somebody who is you know'...people would give...'Oh he's a bit precious isn't he'. I certainly have been asked...'can't we just take this patient to

detain him?’ and he’s having a manic episode in your car to the hospital, and I don’t think a woman would have to do that.

This male Mental Health Officer highlights the same type of expectation and pressure from colleagues as male MHO 16 in that he is also expected to deal with potentially violent situations on the grounds of his gender. The pressure from colleagues is exemplified in the statement ‘he’s a bit precious isn’t he’ which refers to the informant in a critical sense. The implication is that as a male worker he should carry out such work in order that the other workers, presumably female, do not have to. Mental Health Officer 5 does not consider this to be an obligation that he is under. He is clearer than informant 16 that he will not meet such expectations, and seems to resent being asked to the extent that he regards being a male worker in this context as a disadvantage because these expectations are not directed towards female workers. This is a situation of potential misunderstanding and conflict between colleagues which is based on gender.

This informant displays an emotional reaction to being placed in a position of vulnerability and risk to personal safety. Mental Health Officer 5 reacts by stating clearly that he does not want to be placed in positions of risk to his safety. Requesting male workers to do certain pieces of work involving risk can be seen to stem from the categorisation whereby such workers are regarded as being able to provide protection for others from risk. However, these male workers may experience vulnerability and risk towards themselves. There is a fracture then between category and experience, that is, between the category ‘male’ and the experience of male workers feeling vulnerable.

Male informant 5’s view shows variation from the categorisation of ‘male’ with ‘lack of vulnerability’. This is differentiated on the service user-worker level of interaction. Male informant 17 also experiences vulnerability in potentially violent interviews and sometimes cuts them short:

...a number of times I have been involved in the detention of someone younger men who have a history of violence and are strongly opposed to being detained in hospital and it is not outside their level of experience to hit somebody who is involved in their detention. So at those times I tended to be reasonably clear with medical and nursing staff that I would interview them in the company of medical and nursing staff and not do that alone. Having said that I have interviewed people alone and there have been times when I have thought that this person is potentially going to assault me now so I cut the interviews quite short.

Mental Health Officer 17 outlines issues of risk relating to violence and personal safety based on his experiences. These examples concern male younger service users and some consequent personal safety issues for the worker which are based on his assessment of risk.

Male informant 18 also experiences vulnerability:

...it was a young man just a few months ago actually it was February the most recent, there are several, one I was temporarily imprisoned by a male service user, why am I emphasising gender - does that matter? maybe to me.....He didn't do it in a way that suggested he was going to assault me but he certainly did deprive me of my freedom for about it was ten minutes which it was quite a long time but it wasn't too bad that was several years ago.....Recently it was a chap who was really quite psychotic and disturbed and seemed to believe he had some supernatural powers and we were in the process of detaining him going from a 25 to a 26 .....and I wondered if his strange movements were going to include an assault on me and I was trying to strike the balance between giving the interview a chance because of his rights and my rights to not expose myself to too much risk.

As with male Mental Health Officer 17, male informant 18 raises the issues of personal safety and assessment of dangerous, or potentially dangerous, situations by giving examples from his own experience as a Mental Health Officer. These examples are explicitly of situations of risk with *male* service users. He asks himself why he is emphasising gender at one point, in an example of imprisonment by a male service user, stating that perhaps it is important to him. This suggests processes of categorisation, in that the meaning of the situation of being imprisoned

by a male service user perhaps more easily arises from the category 'male' than if the scenario had been one involving imprisonment by a female service user. If the category 'female' is associated with 'vulnerability' generally but the category 'male' is associated with 'lack of vulnerability', then it may be that an act of imprisonment is more readily seen as something that could happen to female rather than male workers, and that could be instigated by male rather than female service users.

It is the possibility of a different meaning based on another experience, imprisonment by a female service user, to which Mental Health Officer 18 seems to allude in his questioning of himself, and why gender is of relevance. Had imprisonment been carried out by a female service user, this would have resulted in an across-gender interpretation mismatching that of the categorisation. That is, a person *not* in the category involving 'vulnerability' generally, would have been placed at risk by someone who is categorised as 'vulnerable'. Such a situation could have held a personal involvement on the part of male informant 18 in terms of understanding his own experience in relation to the categorisation.

A different example of being placed in some danger by a male service user is given by male informant 5:

If I am kind of like halfway through an assessment and someone is getting really agitated or...things are escalating even in kind of like the home situation, I am just going to take myself out of there, I'm just going to leave so no I don't tend to...I recently had a situation whereby, recently a year and a half ago, there was a chap I was seeing in sheltered accommodation with very fixed set of paranoid ideas and who had been wandering around scaring the hell out of his flatmates by sort of like brandishing a knife saying he had to defend the place and I was sitting talking to him on my own and as I was doing so I was thinking 'why am I doing this on my own? How did this come about? Surely there would have been another way to deal with the situation'.



His concerns over personal safety lead him to consider the measure of exiting from interviews with service users when he assesses risk to himself. He also questions whether he should be in a potentially risky situation on his own.

Each of these male Mental Health Officers (5, 17, 18), then, has experienced being at risk from others, specifically male service users. They are concerned regarding their own safety, and sometimes suggest ways to reduce this, for example, working jointly with others in such situations. Their views are not based on considering themselves as having the potential to prevent risk from the male service users without risk to themselves. The category 'male', then, is differentiated and not simply associated with 'lack of vulnerability'. There is 'vulnerability' associated with the category 'male', and in the context of these male worker and male service user interactions, it is to be found in the sub-category of male workers.

In each of the instances put forward by the Mental Health Officers there are two levels of interaction in operation, that is, gender groupings and service user-worker relations. Howe (1994) recognises the power differentials in the latter. He argues in relation to social work:

Professionals are examples of people who find themselves in positions of power. They are able to define both the problem and the manner of its resolution (Howe 1994, p.526).

The problem of safety is defined – by some of the professionals - in gender terms and the manner of its resolution is gender-based. Miller and Bell (1996), as stated earlier, theorise that the agency of masculinity damages men and also predisposes them to do damage. At the level of male worker-male service user interaction, however, it is the male service users who are conceived as damage-doing whereas the male workers are not conceived in this way. The difference is constructed in terms of the male service user as 'other' to workers, both female and male. Such a focus on male abuse, according to Miller and Bell (1996), leads to containment.

This is what underlies the suggestion that male workers should work with some male service users for safety reasons – to contain, and control, if necessary.

The construction of some male service users as ‘other’ indicates division within the male gender group. Flax (1990), similarly to Collins (1991), argues for a both/and conceptual stance which in theorising gender opens up possibilities more than an either/or conceptual stance (Featherstone and Trinder, 1997). The both/and stance points to differences within gender groups as well as between the groups, whereas the either/or stance points to differences between the gender groups. The male group includes male workers and male service users, and each of these is associated with gender privilege. However, in the service user-worker relationship, the workers have additional privilege as professionals – able to define problems (for example, to label a service user as violent) – whereas, the service users have some penalty – not being able to define problems. The male workers are privileged whereas the male service users are *both* privileged *and* penalised. Therefore, this is an area of differentiation within the male gender group and based on the construction of the social worker and service user relation. Differences among men, then, need to be taken into account - as well as differences among women.

The topic of aggressive or violent behaviour from female service users is also raised by two female informants.

Female Mental Health Officer 10, states:

...and in the hospital yes certainly I have felt threatened, I had one woman who was in the Intensive Psychiatric Care Unit and very very volatile and had assaulted the nursing staff...I was aware that that was the situation and she only spoke to me for two minutes and then she left, it was the sort of unpredictability of her behaviour and the known fact that she had assaulted...

Unusually, for both female and male informants, female Mental Health Officer 10 gives an example of a female service user she considers to be dangerous to others.



This exception, then, is of interest as it is within the context female only, that is, female Mental Health Officer and female service user, and the category 'female' is not being placed in a context of vulnerability but rather threat towards.

This differs from the categorisation which is emerging of 'female' as vulnerable.

She further states:

I did a duty visit here....it was an elderly woman and you wouldn't well you sort of think...this woman is 83 I wouldn't start thinking around the possibility of her being aggressive, that is the closest I have ever come to being physically assaulted and she threw things at me...

Again, informant 10 presents an unusual view of connecting 'female' with aggression based on experience. What makes this particularly exceptional is that this example combines the gender 'female' with being of older age and both are often associated with vulnerability in terms of typification.

Mental Health Officer 10 states that the service user's age of 83 prevented her from considering that the woman might be aggressive. Also, this informant laughed at the time of giving this example suggesting that she considers it unusual that an elderly woman should show aggression. I as interviewer also laughed and expressed surprise. The fracture between categorisation and experience is highlighted by my, and the informant's, reactions. The category 'female', particularly when connected with 'older', is not typically associated with 'aggression' and so this experience highlights variation.

Another female Mental Health Officer, 11, states that working with male service users is more threatening to her than working with female service users because the former are more physically strong than the latter. She has, however, had one experience of aggression from a female service user and considers it to have been 'more like equals'. Risk and threat, then, are not attached to the category 'female' in her perspective but to the category 'male'. This female Mental Health Officer,

then, has had a similar experience to that of female MHO 10 concerning an aggressive female service user but her understanding of that has taken a different direction. This is because informant 11 did not experience the female service user's assault as a risk in the way that she has done with male service users.

There is, then, variation between the views of these female informants towards issues of aggression or violence in work with female service users. The categorisation of 'female' as 'vulnerable', however, is divided by the connection of 'female' with 'aggression' or 'violence'.

Therefore, in this section, there has been found categorisation as well as some variation of views in terms of gender grouping and 'vulnerability'.

#### B] *Across-Gender Working Relations*

The categorisation of 'female' or 'women' with 'vulnerability' but 'male' or 'men' with 'lack of vulnerability' informs across-gender working relations as well as same-gender working relations.

Informant 13, male, states concerning female and male workers working together:

...and I think that a female [worker] in those circumstances [work with aggressive male service users] is going to find that extremely difficult and I think that there is very much a role for not to exclude women in those circumstances because then you are strengthening their view, and you get the boy's club...the big boy manages the crazy boy, you know what I mean...but I think it would have been extremely difficult in those circumstances for a female worker to work in that. In saying there might be scope there to co-work or something.

If female workers are excluded in this type of situation, then, it disallows across-gender working relations. Mental Health Officer 13 considers that such exclusion would strengthen the view held by the male service users. He is suggesting that the service users have a discriminatory viewpoint that would be underlined by such a

move of exclusion, and that a 'boy's club', as he states, could result. Another male worker or a female worker might decide that exclusion of female workers is the most appropriate option in the same circumstances perhaps on the grounds of safety. This type of decision-making has been evidenced in my research project.

Male informant 16 experienced a gender-based practice dilemma:

I was Mental Health Officer for a man who in the first meeting said he didn't want a man [male worker] he wanted a woman [female worker]...he was saying 'I am not going to talk to a man I want a woman as my Mental Health Officer'...like choose your Mental Health Officer it was like that, and I thought well fair enough because if it was a woman saying I want a man you would I would say 'well yes I don't have a problem with that'...he would not work with me at all, I would go and see him at IPCU [Intensive Psychiatric Care Unit] and he was just like he would sit there for a minute and turn his back on me and say 'I want out now'...so this isn't getting very far, he did get a woman as a Mental Health Officer yes and things went along much smoother, mother figure who knows, it was just like he felt less threatened...

The service user is specifically requesting across-gender working relations in this example because he wants to work with a female and not a male Mental Health Officer. MHO 16's view is that the male service user probably sees a female worker as less threatening than a male worker (the informant). This difference indicates the categorisation of 'female' with 'vulnerability'.

Male informant 16 also speaks of across-gender working relations:

There are men's men and quite often they are not...they are yes and because I am much more used to working with women, and you might think well they will be happier to have a man, but sometimes it [having a male worker] could be seen as quite threatening...

This Mental Health Officer here constructs gender relations in the service user-worker interaction in a problematic way in terms of categorisation. He gives a view of regarding female service users as probably 'happier' with a male worker, and yet

also at times finding that threatening. Categorisation is assumed in terms of female service users being in a position of vulnerability in relation to male workers, however, it is also assumed that a woman service user may prefer a male worker, that is an across-gender interaction.

Some informants' views are constructed in terms which challenge or do not fully accept the typification of gender relations.

Mental Health Officer 5, male, gives an example of detaining a female service user in hospital. The latter, however, escapes during the process by simply running out of the hospital and informant 5 states:

I remember thinking 'Oh I should really stand up and physically restrain this women from doing that' and then I thought 'no because I won't know how to do it all that well so probably hurt her in the process and may well hurt myself.'

The danger in this instance is assessed by this male Mental Health Officer to be potentially within his own actions in that he may hurt the female service user or himself. He does not consider the service user to be a danger to others, although he does state that she may hurt herself.

Male informant 5 views the female service user as being in potential danger from himself should he try to restrain her. In this case the female service user's actions are assessed in terms of her own vulnerability in relation to the male Mental Health Officer. The worker also considers his own vulnerability in the situation though not in relation to the female service user but to his own actions. The view of this informant, then, indicates categorisation because of the female service user being vulnerable in relation to the male worker. However, there is also a connection made between the male Mental Health Officer and vulnerability, though this is 'on his own terms'.

Another variation from the categorisation concerning 'vulnerability' is to be found in the view of female Mental Health Officer 12. She considers that female workers are less likely than male workers to incite male service users, who have the label 'violent' or 'dangerous', to show aggression. She also considers that female workers are more able to defuse an aggressive situation than male workers. This informant, then, is generally connecting 'aggression' or 'violence' with the category 'male' in that she talks of male service user aggression not female service user aggression. She sees male workers as more liable to incite such aggression than female workers. From this perspective aggression or violence is not associated with the category 'female' but with the category 'male'. This perspective appears to place 'aggression' and 'threat' as firmly attached to 'male' and further to disassociate 'aggression' with 'female' to the extent that women are seen as having an ability to prevent some male aggression arising and to diminish the aggressive threat when it does arise. This takes the category 'female' and its usual association with 'vulnerability', and changes it to being a positive rather than a negative typification. Although the typification holds, it is understood differently in that women are regarded as able to do *to* – they are able to prevent or change some male aggression. Mental Health Officer 12's own experience as a worker is that she has never been threatened verbally or physically, and her understanding of that is based on experiencing this ability as a female worker and using it.

Female informant 10 states in relation to working with someone 'known to be violent':

...sometimes I think maybe if it is a man they may be less likely to actually physically assault you if you are female but then I think probably if somebody is as out of control as that it [the gender of the worker] is maybe not going to make a huge deal of difference...

In stating that a man may be less likely to assault a female worker, female Mental Health Officer 10 is in agreement with female Mental Health Officer 12. However, informant 10 then gives another view by saying that the gender of the worker does

not make much difference if the person is likely to be violent. This places both female and male workers as potential targets of the male service user's violence.

Another female Mental Health Officer, 8, states that defusing aggressive situations does not depend on one's gender but rather on natural abilities or techniques used. The aggression is linked to the mental health problem here and she has felt particularly vulnerable when visiting mainly male service users at home. This informant, then, from her own experience, does not see female workers as specifically having an ability to defuse male aggression. She does, however, regard aggression as associated with the category 'male' since she particularly mentions that it is male service users who have sometimes made her feel vulnerable. As a result of feeling vulnerable at times, this informant for reasons of personal safety, has cut interviews with service users short and has also avoided some situations.

In this section, processes of categorisation have been seen to be instrumental in constructing some Mental Health Officer views towards the topic of safety, with 'female' being associated with 'vulnerability' but 'male' with 'lack of vulnerability'. Featherstone and Trinder (1997) theorise that binaries such as man/woman operate in either/or terms and so force processes of categorisation and division.

Essentialism is suggested in this typification relating to personal safety. There seems to be an assumption in some informants' views regarding physical strength, in that the risk which is associated with certain male service users is described in physical terms, such as violent behaviour. This draws on biological argument and suggests essentialist concepts, such as natural characteristics. As stated previously, biological determinism is criticised as not being able to adequately account for differences among women, and among men.

It is worth noting that the categorisation of 'women' with 'vulnerability' is undergoing challenge and negotiation in the views of some informants, for instance,

by seeing female workers as having an ability to defuse male aggression. The categorisation of 'men' with 'lack of vulnerability' is also undergoing challenge and negotiation in the views of some informants, for instance, by seeing male workers as vulnerable at times.

The views of Mental Health Officers, then, are sometimes constructed in terms of gender categorisations. These relate to both gender groups rather than particularly to either, for instance, the typification of 'women' with 'depression' and the typification of 'men' with 'aggression'. These can have an effect on assessments and decision-making in mental health social work practice. However, categorisations are questioned in some informants' views. There is evidence of variation in some informants' views.

Therefore, there is gender categorisation, as well as variation, in the views of informants relating to mental health and also to mental health social work practice.



## **CHAPTER 7**

### **SOCIAL INSTITUTION**

Domination is also experienced and resisted on the third level of social institutions controlled by the dominant group: namely, schools, churches, the media, and other formal organisations (Collins 1991, p. 228).

The statutory mental health social work service provided by formal social work organisations in Scotland is conducted through specialist, trained and accredited social workers known as Mental Health Officers. The mental health service of these social work organisations is provided principally for the adult service user population. The service operates as a specialist area of social work and it also overlaps with other social work areas of service, such as, criminal justice. The statutory mental health social work service is conducted in conjunction with other professions, such as, the medical profession. It is usually based in hospitals or social work area offices. The service is often conducted on a duty rota basis and it usually incorporates an out-of-hours service.

Itzin (1995), as stated in the earlier section 'Social Work Organisations', suggests that there is a gender culture which is common to organisations. From a research study of a local authority in 1990, Itzin outlines the characteristics of this gender culture. These include that it is hierarchical and patriarchal, sex-segregated and sex-discriminatory. This applies to social work departments since these are organisations.

Christie (2001) focusses on the aspect of sex-segregation. Specifically in relation to social work, he highlights the gendered patterns of occupational segregation. These are both vertical and horizontal segregation. Vertical segregation involves, for

instance, the higher proportion of male managers in social work organisations despite the larger numbers of female staff overall. Horizontal segregation involves variation in the numbers of female and male social workers who work with the different service user groups (Howe, 1986). Recent statistics published by the Scottish Executive (2001) demonstrate the persistence of occupational segregation. These highlight, for example, that the proportion of staff in Scottish Local Authority Social Work Departments in 1999 who were female and working within the provision of services for adults was 90%, and 55% in the provision of services for offenders.

This chapter deals with the gendered aspects of social work departments as formal organisations. Firstly, the aspect to be examined is gender segregation in the form of both vertical and horizontal segregation. The topic of authority in the Mental Health Officer role is related to horizontal segregation. Secondly, the gendered aspects of multi-disciplinary working are studied. This involves the social institutional level of the medical profession as well as that of the social work profession. The working relations of Mental Health Officers and medical colleagues are examined.

Several informants raise the issue of vertical segregation in social work organisations. Each of these informants states that social work is a male dominated profession managerially and female dominated at the lower echelons. The issue of horizontal segregation is also raised in relation to the topic of authority. There is a difference in emphasis between the female informants and the male informants who raise the topic of authority. Those female informants are less at ease with the authority of the Mental Health Officer role than those male informants.

Various issues are raised by informants concerning working with medical colleagues, particularly medical doctors. These issues tend to concern difficulty and conflict in their working relations. They are presented as follows: professional status differences between medical staff and Mental Health Officers; professional

view differences between medical staff and Mental Health Officers; professional communication difficulties between medical staff and Mental Health Officers.

### **Gendered Segregation in Mental Health Social Work**

#### **VERTICAL SEGREGATION**

Vertical segregation is raised as a topic relating to social work organisations by several informants. Each informant makes the point that social work is male dominated at the managerial level and female dominated at the lower levels.

Female Mental Health Officer 4 states:

I don't think it works very well for women who are in a particular situation...with not a lot of family consideration, choices for women or whatever are limited in the department, there are a few women who have made it don't know how many, there are only a few and how they did that is a mystery.

Female Mental Health Officer 7 states:

...and often women being less likely to be given 'what is the word I am looking for?... promotion that's right', so there is the Florence Nightingale bit I think\_around in social work still, and men come in and go shooting up the ladder faster...

Female Mental Health Officer 14 states:

MHO: Female dominated profession at the grassroots

RM: At the bottom, male dominated at the top

MHO: At the top...not likely to change I wouldn't think, not in the near future

These three informants, and myself as interviewer, are clear in the view that female promotion in social work occurs considerably less often than male promotion. This

is an already identified aspect of social work organisation in the literature (e.g. Howe, 1986; Hudson, 1989), however, it is relevant to include here because it is a gender-differentiated aspect of the organisational context within which Mental Health Officers work. For instance, there is cynicism in the statement of female informant 4 that she knows of only a few women who have been promoted and 'how they did that is a mystery'. This indicates that she regards the social work organisation not as a site of equal opportunity but of unequal opportunity.

The shared experiences and ideas of these female informants relate to the social institutional level of social work organisations. However, it is not only female Mental Health Officers who raise the topic of vertical segregation in social work organisations.

Male Mental Health Officer 16 states:

...it is like the old 'why do men go into social work?...to get promotion quicker' and that unfortunately is yes a predominantly female profession with predominantly male managers.....I am still a basic grader but yes it is like that if you are asking 'did I think I would get on being a MHO easier because...[I am] a man in a predominantly female profession?' I would say 'I don't know and I can't think of any practical instance where that is actually that has happened'. It is difficult to tell because maybe a woman would have been treated exactly the same.

This male informant's view is that the social work organisation consists of mostly female workers but mostly male managers. He suggests that the promotional prospects for men could be the reasoning behind some men entering social work as a profession. In relation to specifically working as a Mental Health Officer, however, he states that he is unsure whether his gender has made a difference in the context of the professional organisation. This could be because he is a main grade worker and a Mental Health Officer, not a manager, and therefore the difference which he raises that gender seems to make is not of personal relevance.

Cree (1996) found that, despite individual variations, women and men entering social work training have different histories and anticipate having different futures

within social work. As stated earlier, most male social work students in Cree's study expected to be promoted more quickly than women, and the female students equally acknowledged that men's promotion prospects were better.

There are other differences within social work organisations between women and men workers, such as types of work carried out, and this is known as horizontal segregation.

### HORIZONTAL SEGREGATION – AND THE TOPIC OF AUTHORITY

Women are generally engaged in tasks demanding their supposedly 'natural' capacities to care for others, whereas men are more likely to be in positions requiring the use of authority and the administration of control over others (Hudson, 1989). Mental health work has been regarded as an area which attracts male workers. Dingwall et al. (1988) argue that historically mental health work has been dominated by men. Howe (1986) argues that there is a preponderance of men in the controlling work associated with mental health work.

I interviewed both female and male Mental Health Officers and some variation was found between the gender groups relating to horizontal segregation. This variation concerns several of the informants and relates to the topic of authority in mental health social work. Those female workers are less at ease with the authority of the Mental Health Officer role than those male workers. From my own experience, the role of the MHO often involves the use of authority particularly in taking measures of detention which are against the will of service users. This is the sense of authority which Clark and Asquith identify as: 'A person may be *in* authority *over* someone else' (1985, p.43). They state that this kind of authority is most clear in social work where the worker acts as an agent of the legal system. This is part of the scope of the Mental Health Officer role.

In my study I found that there is a distinctive qualitative difference in emphasis and terminology between female and male informants in terms of stating their ease with the authority of the Mental Health Officer role. No female Mental Health Officer uses the word 'authority' in relation to the role, specifically 'sectioning', whereas four male Mental Health Officers do use the word 'authority'.

Female informant 12 states:

I don't have any doubt that there are times when people need to be sectioned. I am very comfortable about sectioning people. If I were in the state that I see some people in I would like somebody to section me so that I am not roaming about potentially going to hurt somebody I care about or be acting in some sort of awful disinhibited way that I would be mortified about when I was again well.

This female Mental Health Officer is very comfortable with the role of 'sectioning', and this makes her an unusual case amongst the female informants, even those who are also at some ease with the role. She does not, however, use the term 'authority'.

Female Mental Health Officer 6 states in relation to 'sectioning' as part of the role:

I suppose before I did the course I was really quite I was against it but that was before I knew the other side of the story and with the sections that I have been involved with so far I think they have all been necessary. I can see why it was necessary to do it ['sectioning'].

Although this informant is at some ease with taking detention measures as a part of the role, she is not as certain or comfortable as informant 12 is in relation to 'sectioning'.

Female informant 4 states:

I think that for some people at some times in their lives they do need to be sectioned, I am quite convinced of that, that they need to be detained against their will because they are not competent to make these decisions for themselves, so in terms of being involved in that process I can see the purpose of it. I mean it's obviously not something though that I would want to do lightly,...there are rights and I would have the responsibility to ensure that I do what I can to look at alternatives [to 'sectioning']

Female Mental Health Officer 7 states:

‘Sectioning’ I think in most cases is done...my involvement has been part of a group which has been done sensitively and caringly, and that people in actual fact have been very ill at the time of ‘sectioning’, and they have been really a danger to themselves and others.

Both of these female informants, 4 and 7, then, regard ‘sectioning’ as necessary at times. These informants do not emphasise the authoritative role and decision-making of the Mental Health Officer. They accept that that is part of the role but place it in the context of how it is carried out and what is taken into account. They seem to give some justification for their decision-making concerning detention issues.

Some male informants are much more definite about accepting the authoritative aspects of the role. Male Mental Health Officer 5 states:

I am aggravated on occasions by people who say, and they don't tend to be social workers actually they don't tend to work within statutory services, people say ‘how can you do that? who do you think you are? saying you've got that authority over people’. I have got that authority over people and it is enshrined in law for a reason, which is that some people are so unwell they are going to hurt themselves or others and I'm suspicious of the kind of ethical cop-out that says ‘well you know people just have to be allowed to get on with what it is they are doing’, I am always suspicious about ‘well I'm not going to take active steps to do something because I feel that is the ethical thing to do’. I take active steps to do something by the nature of the job and I think that is the ethical thing to do.

There is a much greater degree of certainty in the view of this informant that when he is involved in ‘sectioning’ it is the right thing to do. This certainty is stated quite aggressively, arguing against other perspectives to the point that he talks of being ‘suspicious’ of a view that is anti-detention measures. To justify his perspective he places his reasoning on an ethical basis and also mentions that the Mental Health Officer role in terms of detention is placed within the context of legislation. This informant, then, supports his perspective with various arguments and places it forward strongly and in terms of the authority that he has as a Mental Health Officer.



As the interviewer, I was aware of feeling that, if I had wanted to, it would have involved some difficulty to respond with an opposing argument because of the strength of feeling with which he argued and the negative context in which he had placed opposing views. This display of emotion from the informant shows that the subject is important to him.

In relation to what the role of a Mental Health Officer involves, male informant 1 states:

...not being afraid to use your authority if the situation warrants it.....and on top of that you know I think you need to be I don't mean aggressive, I think you need to be assertive, you need to be confident about what you are and the value of what you are doing...

Similarly to male Mental Health Officer 5, this male informant puts forward a strong view regarding the acceptance and the use of the authority of the Mental Health Officer role. Rather than arguing the bases of that authority as informant 5 has done specifically concerning detention, he takes the authority of the role as read, and places it in a context of how the authority needs to be utilised. This utilisation is in terms of assertion and confidence, he states, because a Mental Health Officer needs to value what it is that they do. This seems to be quite a crucial point in that in order to align oneself with the Mental Health Officer role, and particularly the authoritative aspects of the role, it would seem necessary to be in agreement with these. Both of these male Mental Health Officers are in such agreement to the point of assertion of the role.

The views of these male informants highlight that authority needs to be carried out, that is, it is a remit *to do*. Male informant 13's perspective is clear that making a decision regarding detention is something that needs to be done when it is assessed as being required:

I suppose the bottom line for me is I've seen cases where, and you still see situations where, everyone is reluctant to do this terrible dirty deed of 'sectioning' and people aren't being responded to and the distress that that can cause. I mean why sit around for three or four days trying to be nice about it when it's clear that that person needs protecting....I think if we

make that judgement it is a cruelty to basically 'piss around' with it after we have done that for the sake of somebody's feelings. The majority of people you speak to after a section if it has been an acute psychotic episode agree with it.

How the decision is carried out is what is important to Mental Health Officer 13 here particularly in terms of timing. Mental Health Officer 13's confidence in his own decision-making abilities regarding 'sectioning' lead him to hold a critical view of those who carry out the authoritative role in a different manner. This informant's perspective implies that those who are more hesitant are not carrying out the authority of the role properly, that is, they are not doing what is expected of them in an authoritative manner. Nevertheless, Mental Health Officers who take longer to make decisions can still make them and this also appears to be carrying out the authority of the role. What this informant has highlighted in his view is that authority is associated with an authoritative manner, that is, with a manner of not hesitating and of getting things done. Informant 13 supports such an approach by appeal to a rights perspective, that is, the rights of the service users are abused if there is too much hesitation by the Mental Health Officer and this can cause distress and can be regarded as cruel. None of the female informants emphasise authoritative manner.

Male informant 1 states in connection to 'sectioning':

I have a lot of formal and informal contact with very articulate committed people who are coming from the users' wavelength and very clear that they regard that aspect of what I do as ...a really horrible thing to do to someone...and I take on board that it must feel like that often when it is happening to you and even afterwards but I have never been troubled by having to do it, I've never been troubled by consenting to it ['sectioning'].

Again, as with male informant 5, this male Mental Health Officer finds the authoritative decision-making which is involved in detention to be straightforward. Male Mental Health Officer 16 also has no problem deciding on detention measures if assessed as necessary:

I have never had a problem with giving consent if I felt that is what was necessary.

Male informant 19 in relation to 'sectioning' states:

...in a way I think we kid ourselves on that we don't have this authoritative role, it's maybe about being clearer about it about using it.  
and also:

Done it ['sectioning'] lots of times so yes at times I can do it without qualm and thought, I would like to think I don't and always give it good thought.

There is the risk, then, as highlighted by this Mental Health Officer's statement that 'sectioning' can become routine and be carried out without due thought. Such a possibility suggests too much comfort with the authoritative role.

The male Mental Health Officers discussed so far have had no real difficulties with the authority of the role. As Hudson argues:

Social work tasks that involve an explicit use of authority and control seem to be more attractive to male social workers than those involving a greater concentration on the organisation of care for dependent people (1989, p.87).

The female and male informants, then, who raise the topic of authority in mental health social work, are differentiated by gender in their views. The male workers associate more strongly with 'authority' than the female workers. This constitutes a gendered aspect of the work of these Mental Health Officers.

Male informant 15 suggests that these understandings within gender groups towards authority can be found in the views of service users also. Informant 15 gives an example whereby authority is regarded by a service user as not fitting to a female Mental Health Officer but fitting only to a male Mental Health Officer:

...there have been cases that have had different Mental Health Officers or where clearly the patient or service user or whatever terminology we want has not taken well to women...they see in positions of authority, and I think

this was particularly an older woman [service user] herself that didn't think a younger woman [worker] had any authority or right to come and do these kind of fairly powerful things and basically make sure that someone went into hospital. She [service user] clearly did not see that as something that should have been done by you know not only that particular woman but women in general, and I think whether it was because that had already been done my experience of working with her was far less hostile .....it didn't seem to have that edge of antagonism or refusal to cooperate or discuss things I think she may well have had had she carried on working with the same [female] Mental Health Officer. And I think there was a gender aspect to that not just the fact that she identified that person as the person that had been responsible for her having to stay in hospital...

This Mental Health Officer outlines a practice situation where the female service user's view is constructed in gender discriminatory terms. The position of authority which any Mental Health Officer has includes the responsibility to be part of a multi-disciplinary decision-making process concerning detention. It is, technically, the same role whether it is a female or male Mental Health Officer. However, as the service user-worker relation is socially constructed (Clark and Asquith, 1985), assumptions are made by the service user and assumptions are made by the worker which are integral to the relation. In the instance outlined, the assumption of the female service user towards the female Mental Health Officer indicates gender-based discrimination.

Male informant 15 talks of 'women...in positions of authority' as problematic from this female service user's point of view. In stating this, though, there is an underlying assumption in the context of the interview that I as interviewer will understand this as a problem, that is, I will know what he means. In cultural terms, of course I do as my response indicates:

I suppose it is the older generation being more accepting of male authority is that it?

The cultural context links 'male', 'older age' and 'authority', and the example outlines a situation which is different to this context and produces a reaction in the service user concerned.

In this instance, the view of the service user towards a person 'in authority' is constructed in terms of gender and age. This raises the question of whether the authority of the role can be carried out in certain circumstances. For example, the 'target' of authority, that is the service user in the example given, is not simply static but may be able to refuse as well as to accept such authority. This particular female service user refuses female Mental Health Officer' authority but accepts male Mental Health Officer' authority, reflecting a cultural bias, also influenced by age. Such bias could also explain why the female informants do not associate themselves readily with 'authority' and do not use the term.

There is a suggestion from male informant 5 that state authority is represented in male terms. He states:

When you have actually reached the stage of completing your assessment and you have decided that somebody is requiring to be detained or conversely that somebody requires to do something, attend to something, be somewhere, take something to avoid being detained, there is something about being a male with a shirt and tie on saying 'you know this is what you have to do' which is actually terribly advantageous...and in that sense of the role you are kind of like the representative of the state and generally representatives of the state tell you to do things with a sense of authority from men, so I think I will probably get an easier time than some of my female colleagues.

The advantage which male Mental Health Officers have over female Mental Health Officers, according to male informant 5, is that once a decision has been made, it is the stage of telling someone what to do which is made easier. In such a case the decision is implicitly one of intervention by the Mental Health Officer. Again, the authority is seen as being something to be done, to be carried out, and also relevant is how it is carried out, that is, with a sense of authority – assumed to be 'male'. This suggests a possibility whereby a female Mental Health Officer could make a decision, particularly to detain someone, but not be seen to have the full authority necessary to ensure that the decision is readily carried out.

There is, then, a stated connection between 'male' and 'authority' found in some of the male Mental Health Officers' views and experiences. Also, with these informants it is clear that they personally are at some ease with the authority of the Mental Health Officer role, and although this can also be said of the female informants studied in this section, their ease is not expressed to the same extent. The linking of 'male' and 'authority' is suggested by the more confident and certain responses from the male informants compared to the less certain responses from the female informants towards the authoritative aspects of the Mental Health Officer role.

The topic of authority, then, in statutory mental health social work is raised by several informants and this relates to horizontal segregation. A difference between the genders has been noted towards the authoritative aspects of the MHO role.

Gendered aspects of Social Work Departments as organisations, then, have been found in some informants' views to consist of vertical and horizontal segregation. Also, in some informants' views, the topic of authority is connected to horizontal segregation in Mental Health Officer work, and has been found to be constructed mostly in gender-differentiated terms.

### **Multi-Disciplinary Working**

#### **WORKING WITH MEDICAL COLLEAGUES**

Various issues were raised by the informants concerning working with medical colleagues, particularly medical doctors. Several informants, both female and male, have found some difficulty in working with medical colleagues and sometimes this



concerns gender issues. These informants, then, construct relations with medical colleagues, particularly doctors, primarily in terms of difficulty and conflict. This construction has implications for the negotiation of professional boundaries and responsibilities in multi-disciplinary communication and planning.

### **Professional Status Differences Between Medical Staff and Mental Health Officers**

Differences in status between medical staff and Mental Health Officers are raised by several informants. Male informant 19 states regarding doctors in relation to MHOs:

Your differences in status are pretty marked. One earns about three times as much money.

Also, in the context of a conversation he had with the manager of the hospital where he works, he states:

...the ultimate decision about care and treatment is not made by the doctors but rather there will be doctors among the decision-makers on the trust board, but the consultants always had their fiefdom and that will vary sort of ward to ward obviously and there will be some more welcoming rather than others and more open to the debate around that...I suppose it is that some are more conservative and others are thinking much more broadly but there is a push to community care and to multi-disciplinary approaches to be able to show that you are doing care programmes and all the rest of it...people are interested in outcomes

This informant regards the status of doctors, particularly consultants, to be high in comparison to their colleagues, such that the wards some consultants work in are considered to be their individual fiefdoms. However, this status is placed in the political context of community care and moves towards multi-disciplinary practice. This context seems to suggest that the power of such medical staff could be diminished. This power shift may occur because of accountability, such as 'outcomes', and the working approach which is taken, for instance, 'care



programmes'. Multi-disciplinary approaches tend to share the decision-making and this sharing leads to the lessening of power of individual professionals. Shared decision-making suggests the need for effective communication between professionals.

Effective communication between professionals can break down, or become distorted, if individuals are not accorded respect. Male informant 16 gives an example of working with medical staff where he was placed in a junior position in terms of how he was treated. He states in relation to an assessment of a woman in hospital:

...and when I spoke with her I found she knew where she wanted to go to, she had friends, she wanted to leave the hospital and there was no medical reason to keep her in. I couldn't see any symptoms of mental illness and then I told the doctor on the ward she said 'I think you are wrong' phoned up a higher doctor and he starts barking at me down the phone saying 'what is your alternative what is your alternative?' So I said 'well alternative to what if I don't think she can be kept in the hospital then I don't'. You are meant under the Act to provide an alternative but she was well enough just to walk out so we agreed eventually, after much getting shouted at...where she was going was Cambridge...we gave her the information about where she could go in Cambridge should she feel unwell, just information like that but that felt like really being put on the spot turning it down...

This example is one of poor working relations, whereby the informant considers that he has been inappropriately treated by his medical colleagues. This Mental Health Officer's experience is one which in this instance involves the ward doctor asserting authority over him but not directly. In order to 'bark' and shout at the Mental Health Officer, the other doctor concerned presumably sees the MHO as junior to him. It is a highly unlikely scenario where a junior colleague will shout at a senior in such a manner, except in exceptional circumstances. Under the terms of the medical model and its application to practice, Mental Health Officers are usually considered secondary in decision-making to medical staff, particularly doctors and especially those of high rank, such as consultants. However, under the terms of the Mental Health (Scotland) Act 1984, Mental Health Officers have a duty to consider whether

there is an alternative to hospital admission, and they are therefore placed in a position which can require them to make a different decision to medical staff and doctors. These circumstances create situations of struggle in many instances and it is because of the struggle that rank and status issues make a difference.

Emotional power seems to be attached to professional status with consultants wielding the most power. Female informant 10 states:

...initially especially I think with psychiatrists and consultants probably [I] did feel a bit sort of not overawed but you are made to feel very aware of their position you know their feelings about their position.

This informant's perspective highlights that it is not position alone which produces differences but the attachment of the individual consultants to their position, that is, it is their feelings concerning position which matter. MHO 10 puts it that she was 'made to feel very aware' of their feelings. This suggests an imposition of feeling whereby status is expected to be upheld or some feelings will be shown by those who consider their position to be usurped. This imposition of feeling seems to be emotional power attached to professional status.

The status and power held by medical professionals can be used to keep other medical professionals in line. Female Mental Health Officer 11 states:

I liked the approach at Dingleton as well which was not to be not particularly medical model approach you know much more social approach and holistic approach to mental health and not institutionalising people..... and going to the Royal Ed was like a slap in the face with a wet kipper.....I was fortunate I worked with a consultant who...was working in the community, and he did have a kind of multi-disciplinary approach to the point that really he was more or less run out of town I think by the establishment at the Royal Ed and he is now working at Dingleton.

This informant's perspective raises the issue that differences in status are not the result of position alone, but are also decided by other professionals in terms of how an individual professional carries out their role. The example illustrates that the

consultant who is willing to share power and decision-making, since he is in favour of a multi-disciplinary approach, is excluded from a group of consultants who want to conserve power within their own hands. There are differences of status within a professional group, then, as well as between such groups.

Differences of status between professional groups can have detrimental consequences. Female informant 14 states:

I decided that I personally found working in a hospital environment really difficult. I found the different agendas quite difficult to work with...and social work was certainly very much seen as the least important of the professions involved in the care of the patient and usually was the one which took the backlash if there were problems in people moving back out into the community... so the medical model is difficult to work with...very different agendas, so I chose to come back out into the community.

There are difficulties working with the medical model in a multi-disciplinary context for this Mental Health Officer. This experience made her decide to leave hospital social work and to do community-based social work instead. A major personal decision, then, has been made by this informant which stems from the effect of working within a multi-disciplinary context. She further states:

My experience has been male consultants tend to, more than female consultants, on balance they tend to be more focussed on the medical model.....I think the medical model does not necessarily take into account gender issues.

The medical model, then, in this informant's perspective, places social work at the lower end of the professional hospital-based spectrum. She is of the view that it is mostly male consultants who adhere to the model. The emphasis here is on hierarchy and positioning within decision-making power, and Mental Health Officer 14's experience is that male consultants tend to focus more on these power-based differences than female consultants.

Other Mental Health Officers also note gender differences in multi-disciplinary work. Female Mental Health Officer 11 states:

...there is quite often a tendency though, and I don't think it's just because of being a Mental Health Officer, is for male and to some extent female medical staff to be a bit more autocratic...and I mean because I have worked so long in hospitals I am not in awe of doctors but they definitely do try it on I think more with a woman than they do with a man.

This female informant agrees with Mental Health Officer 14, also female, that the gender of the medical staff tends to make a difference in how focussed the medical personnel are on their power and decision-making authority. She has found that the male medical staff tend to be more focussed on power, as suggested by the term 'autocratic', than the female staff tend to be. From her experience as a female Mental Health Officer, she infers that male doctors 'try it on', meaning 'try to assert their authority', more with female MHOs than with male MHOs. This, then, is not mere difference of status due to position but is complicated by the assumed power differential of gender, that is, the male gender over the female gender. This assumption is taken to be part of the male doctor's perspective in such a scenario. The working relation of the doctor and Mental Health Officer will be affected by such a patriarchal perspective, in that if the female Mental Health Officer is perceived as 'lesser' by the male doctor because of position and gender, and the Mental Health Officer is aware of this perception, then she has to somehow disregard or change such a perception in order to fully take part in discussions of decision-making and judgement concerning patients.

Male Mental Health Officer 1 also considers that gender is an issue in terms of working with the hospital system, and with doctors in particular. He states:

I do believe for all the wrong reasons it is probably advantageous that I am a man...going into a lot of the situations because there is still a lot of sexism around in hospitals, and there is a lot of sexism around in social work as well but I think in hospitals particularly you get, you know they are still a bit like that. Most consultants tend to be men, more and more women but you know

that is still around. You tend to notice a bit of a difference with kind of generations, younger consultants are generally women and the older ones tend to all be men.

This informant's statement supports the interpretation of the last Mental Health Officer's perspective that gender makes a difference, since if being a male MHO is an advantage because most consultants tend to be male and there is sexism in hospitals, then being a female MHO will be a disadvantage. This difference is implied in the statement of female informant 11 that doctors 'try it on' more with a woman (taken as a female Mental Health Officer) than a man (taken as a male Mental Health Officer). Also, my experience of working as a Mental Health Officer is that status differences between doctors, particularly consultants, and mental health social workers are often pronounced, and it is my perspective that gender differences form part of this. Often Mental Health Officers work with male doctors and consultants, and in my experience the across-gender working relation between female MHO and male doctor can sometimes feel like another hurdle to be overcome, for instance, in terms of being listened to. Gender-based difference is directly mentioned by these three informants – female Mental Health Officers 14 and 11, and male Mental Health Officer 1.

Some of the Mental Health Officers, then, are quite keenly aware of differences in status particularly pertaining to their own position vis-a-vis that of medical staff, especially consultants. Some informants have also found that gender makes a difference in the working relation between them and medical staff.

### **Professional View Differences Between Medical Staff and Mental Health Officers**

Professional view differences sometimes occur in practice based decision-making or judgements.

Male Mental Health Officer 9 states:

.....the pressures one feels, you try to make a careful...cautious...you try to make an informed judgement but you are under pressure by another professional group, police, doctors, have their own issues and you get caught up you know in these situations.

This informant talks of pressure caused by differing professional concerns in situations of assessment concerning detention. The specific perspectives he is concerned with are those of the police and of doctors. In terms of practice, this Mental Health Officer states that he has been 'caught up' by these pressures, which suggests that he has made decisions he may not otherwise have made if he had not been influenced by these other professional groups' issues.

Female informant 7, who is hospital-based, also finds difficulties in multi-disciplinary working:

I actually think dealing with the poorly trained multi-disciplinary team is actually more stressful for me than working with one to one service user.....I think in Edinburgh we work in a medical model so I think that has got quite a big clash with social work training.

Again the point is raised that different professional groups have different perspectives and that these differences can lead to problematic working relations. The existence of problems in working relations suggests that a policy of developing understanding of the roles of other disciplinary groups could be helpful.

Male Mental Health Officer 16 states:

I have been involved in sectioning somebody with kids yes that was one where I felt I got it wrong. I actually had been bullied by staff into going for it that was a 26 [scope: 28 days detention] yes I wasn't involved in the 24 [scope: 72 hours detention] but I was involved it was emergency social work I was involved in the 26.....I saw the woman I felt she was ill but I felt she was now saying she would stay in hospital where up to that point she had been saying she wouldn't and she had two children and I consulted with the hospital staff and they were very and the senior registrar was very much like



‘Oh yes she says she will but she won't she won't stay as soon as you go she won't’ and I was swayed by that argument and I found out later that they hadn't actually seen her that day and she had actually changed because her children had been into see her.....so it was a 26 which should never have happened basically.

The use of the term ‘bullied’ indicates that the Mental Health Officer felt under strong pressure to agree with the doctor and four nurses. This direction of pressure is in alignment with the difference of status which places Mental Health Officers as junior to medical staff, doctors particularly. However, in this instance, the Mental Health Officer may also have felt outnumbered towards being able to form a different opinion. He did regret the decision he made afterwards, believing it to be the wrong one for the patient. It is worth noting at this point that this is a male Mental Health Officer who has been swayed by pressure from medical colleagues, in relation to his decision-making or judgement.

As interviewer I state in interview with female Mental Health Officer 14:

...the Mental Health Officers who work in the hospital, they would say that they retain their own professional perspective and view and at times that goes along with the medical view and at times it doesn't but personally speaking when I went into hospital I usually found it a bit of a struggle to maintain totally you know my own perspective...because sometimes it is just hard to say...because everybody would be going right along the medical model line and you would be thinking ‘well maybe I am wrong here, maybe that is the way it should be’, and it's quite hard sometimes.

Similarly to other Mental Health Officers, I have also experienced pressure in situations with medical colleagues in terms of decision-making concerning service users. This pressure need not be as overt as in the case of Mental Health Officer 16 but can be fairly subtle. For instance, in a hospital-based inter-agency meeting where each professional member puts forward an assessment and recommendation regarding any action needing to be taken concerning a patient, I have been in the circumstance where each professional apart from myself has, in my view, taken a medical rather than a social perspective, and that can be a difficult position to be in.



Therefore, from my own experience as a Mental Health Officer, I can understand the pressure which male Mental Health Officer 16 states he was the target of in a hospital setting. This experience of pressure, then, is an across-gender one which contrasts to the statement by male informant 1 that being a male Mental Health Officer is advantageous because of the sexism to be found in hospitals. Male informant 16 has not found being male advantageous in the situation outlined. Being male, then, is not uniformly advantageous in these informants' views.

Other informants who raise the issue of struggle between the medical profession and Mental Health Officers in terms of decision-making are mostly female. These informants usually put the struggle in terms of confidence in the role. Mental Health Officer 14, female, states in relation to giving a different view to that of medical staff:

You have to be very confident to do that.....You have to have really good support that will back you up as a social worker up against the medical profession.

This informant succinctly puts her case that to put forward a different perspective to the medical profession requires confidence from the Mental Health Officer. She also regards support of the Mental Health Officer as a necessity in such a situation, meaning support from social work colleagues and management. The phrase which this informant uses - 'up against the medical profession'- reveals an area of professional struggle, whereby the viewpoint of the Mental Health Officer is outwith that of established opinion. Informant 14 is relating from the position of being outside the medical profession in mental health work. She states how difficult that outside position can be to speak from and be heard. It is a professional interaction which is biased in favour of one viewpoint, from the experience of this Mental Health Officer, and this bias makes open discussion problematic.

Female informant 6 has also found some struggle in working relations with other professionals, such as GPs and psychiatrists:

I am feeling a bit more comfortable about it [working with medical doctors] now. I hated it in the beginning but that was just I think my lack of confidence, and I suppose my own upbringing to look up to the doctor and the doctor was always right, that is what I mean 'yes doctor no doctor' but I certainly don't say that, not now anyway...and I think the more competent I get and the more I learn I feel OK now about...putting my view across if it is different from the medical which worried me in the beginning. 'How am I going to do this? How am I going to cope with this?'...but I do it and I suppose the more I do it the more competent I feel.

Again, this Mental Health Officer has experienced the struggle of putting forward a different view to that of medical opinion, and relates that to lack of confidence. However, as her competence in her role developed, and presumably her confidence, she began to find it easier to present a different perspective to the medical view. Confidence in her professional role as Mental Health Officer is central to this informant's experience and developing point of view vis-a-vis the medical profession.

Confidence in professional role is also important to female MHO 4:

I think professional confidence in your own role...because you are going to situations where you are sometimes in conflict or sometimes having to ask questions or challenge, not necessarily always to kind of disagree, but often to clarify the situation.....so the ability to ask questions and get more information and challenge and discuss things through with people...and it was great to do that because the consultant and the registrar, both, were happy enough to sit down with me and be open about what they are thinking and what their thoughts were and weren't defensive which sometimes you can come across, so it's good to be able to do that but you need some confidence to be able to do that to know what your role is and responsibilities are.

This informant regards confidence as important, particularly in situations of working with medical staff. Similarly to female Mental Health Officer 6, female informant 4 sees professional ability in the role as increasing confidence and making discussions, even challenging ones, easier to carry out with medical staff, in this instance a consultant and a registrar.

The Scottish Office (1994) found from research into the role of the Mental Health Officer that some MHOs felt more confident than others about challenging decisions made by medical staff concerning detention. More experienced mental health social workers believed that they were still in a weak position on detention issues compared to medical colleagues.

Female Mental Health Officer 3's experience includes struggle with medical staff in decision-making concerning detention:

With experience it's alright to say 'no I don't agree'...you can only do that with a bit of experience, it's quite hard to say no to psychiatrists.....It's quite hard you know because a consultant psychiatrist is saying one thing and you are saying something else you know a consultant psychiatrist you still kind of feel...it's quite hard to do it..... it's such a sort of like a system itself the hospital and it clearly sometimes takes over you know and sometimes there is this debate about section 24 [scope: 72 hours detention] and when the 26 [scope: 28 days detention] should be considered and you know you can see the doctor saying 'Oh God I'm going to have to come in on a Saturday morning, and they are going to have to call out EDT [Emergency Duty Team]' and you think well yes but that is right because it is a 72 hour order you know, 72 hours is how long it runs for and as you say some people's situations change, I mean they might decide to take medication or they may decide whatever...

This informant has experienced working with medical staff as a struggle at times, however, she also considers that more experience as a Mental Health Officer makes it easier to have a different view to the medical one. During the interview I came to see informant 3 as taking confidence in the MHO role when explicating details of the legislative process Mental Health Officers are involved in, such as decisions regarding what section should be considered and when, in relation to service users. She seems to consider that there is a difference in status between herself as Mental Health Officer and a consultant psychiatrist, in stating how hard she finds it to disagree with the latter.

I concur with her perspective of the hospital as a 'system' from my own experience as a community-based Mental Health Officer required to attend meetings and visit patients in hospital and so on. There is a sense of being an outsider, though this sense can diminish through time and the experience of working together.

The Scottish Office (1994), as stated earlier, carried out research into the role of the Mental Health Officer. It was found that hospital-based Mental Health Officers had the advantage of knowing other professionals in the hospital which led to easier discussion and negotiation between them. However, Mental Health Officers outwith the hospital were found to be more independent. My experience as a Mental Health Officer also suggests this difference between hospital-based and community-based Mental Health Officers.

Male informant 1 also raises the issue of struggle in the working relations of medical staff and Mental Health Officers:

I think you need to be assertive, you need to be confident about what you are and the value of what you are doing because sometimes if you aren't you will very quickly get side-lined in that kind of multi-disciplinary context particularly on the medical side...so you need to be clear about what you are doing and where you are coming from in that sense.

The need for a Mental Health Officer to be confident, then, particularly when working with the medical profession is stressed by this male informant. This view stems from experiencing the struggle of being heard in a multi-disciplinary context though he does not outline how such struggle feels. Based upon the views of the informants who have experienced multi-disciplinary struggles, it is worth noting that these struggles apply to both genders.

Another male informant who experiences this type of struggle is MHO 5. He states in relation to a guardianship application:

The GP is not keen on doing the second medical recommendation because he has interviewed her [service user] twice and he says he doesn't think that she is actually all that confused. I think that this is because she has an extremely good social facade and that maybe the GP is not as good at doing assessments in terms of people with dementia as myself he said arrogantly or the care of the elderly psychiatrist, so we are going to have a case conference on Thursday morning at half past eight in the morning because that is the only time that the GP can come along so we are being flexible with regards to that...

This Mental Health Officer had an emotional reaction to the General Practitioner in this situation. This emotion is seen not only in what Mental Health Officer 5 states but also in how he states it, that is, with some feeling, with emphasis. Not only does this informant disagree with the General Practitioner's assessment but he also suggests that the doctor is less flexible in terms of arranging a meeting. This latter problem could be simply because the doctor's timetable does not allow for too much flexibility at that point in time. However, the emotional reaction from the professional disagreement shades into other areas, such as, arrangements to meet to discuss the case. This shading or overlapping is apparent in the viewpoint of the Mental Health Officer. Although more female informants raise this topic of professional struggle, it is as stated, an across-gender experience.

Male MHO19, on the other hand, regards it as appropriate at times that Mental Health Officers and medical staff disagree, even passionately. He states:

The rivalry is not necessarily a bad thing, the idea that it should all be consensus and think alike is, we have been talking about this with the new parliament we don't want all the shouting and bawling at each other, well if some thing is serious then maybe we should shout and pull each other about...

In terms of multi-disciplinary working, allowing shouting and so on could jeopardise relations. Disagreement between professional groups does seem inevitable but how that is put into practice is an important issue because the emotional level associated with the act of shouting arguably lessens the

professionalism of the relationship, and the lessening of professionalism puts the standard of practice at risk.

Difficulties in terms of working with medical staff and the medical model, then, are often raised by the informants and are not single-gender issues. Female Mental Health Officers 14, 11, 10, 7, 6, 4, and 3 raise the issues and so do male Mental Health Officers 19, 16, 9, 5, and 1. It is the case, then, that more female informants (7) raise the issue of such problems than male informants (5). Also, the different ways in which female and male informants describe their experiences suggests that the difficulties may be felt in a different, perhaps deeper, way by the female Mental Health Officers. These female officers tend to talk more of their feelings about experiencing problems than do the male Mental Health Officers. For instance, female informant 7 in talking of the multi-disciplinary team she is part of, states:

I think I have to say sometimes I put my hands on my head and I think 'you [the team] really really haven't a clue, you haven't'...

Also, female informant 4 states:

Frustrating is working with some personnel, some doctors, one doctor if I am honest is most frustrating just because there is not a great deal of professional respect and I don't respect him, particularly, I don't trust him...

Male Mental Health Officers 1 and 5, on the other hand, do not directly mention their feelings concerning the professional struggles they describe. There seems to be a difference in the depth of emotion expressed between some of the female and male informants in terms of working with other professionals groups, particularly the medical profession. This difference may be due to differing social acceptability of expressing emotion between the gender groups, that is, women may express a greater range of emotions more readily than men.

Gender difference, then, is shown to be an issue in this multi-disciplinary context, in that more female informants raise the struggle that they have experienced between



themselves as Mental Health Officers and medical staff, particularly doctors, compared to the male informants. Also, how the female Mental Health Officers talk of such struggle tends to be different, more personally involved and emotional, compared to the male Mental Health Officers. As noted earlier, gender making a difference in this area is highlighted directly by three of the informants, two female and one male. Gender, then, seems to matter to some informants in the multi-disciplinary context, specifically between medical staff and Mental Health Officers.

### **Professional Communication Difficulties Between Medical Staff and Mental Health Officers**

Female informant 14, who is a community-based Mental Health Officer, has avoided communicating with medical staff sometimes:

I usually find nursing staff are helpful and are more inclined towards the social model of intervention and came to be involved in looking at the individual's social circumstances, the supports available, they are much more in tune with that. Consultants I tend not to seek contact with them to any great extent, I will go along to ward meetings when we are looking at discharge plans but I will probably spend most of my time with the nursing staff and the individual involved in working out a discharge plan that we can present, and the medical staff involved I usually only seek out where I do need a clear diagnosis so it's at the point of detentions mainly that I would have most of my contact.

This Mental Health Officer has experienced difficulties with medical staff and this has shaped her perspective towards consultants particularly. The view of this informant has consequences in her practice as a Mental Health Officer, such that she prefers to work with nursing staff rather than consultants and so she does not seek contact with them on a routine basis. Usually she will contact a consultant only when detention needs to be considered. Arguably this might not be in the best interests of the service user, since more communication between professionals often leads to sharing of information and knowledge, and then to more informed decision-



making. Also, professional relationships need some interaction to develop and limited contact will not aid this process.

Female Mental Health Officer 14 is doubtful of how much attention is paid to her work by consultants which could explain her view. She states:

The medical model is the main model of intervention until you are looking at discharge, until the person is back out in the community...your [the MHO's] social circumstance reports...look at the social context of the individual and that is really helpful but thinking about it now I wonder why I bother doing it [the report] because it very rarely informs the medical practitioners or it doesn't appear to inform their practice, it's still about the treatment plan...

According to this informant, the Social Circumstance Reports which she writes are mostly ignored by the doctors in their decision-making. These reports are meant to inform the medical staff viewpoint concerning, for instance, the discharge of a patient to the community. The fact that this Mental Health Officer considers these reports to be regarded by the medical staff as of little consequence may underline her own decision to have as little contact as possible with medical staff, such as consultants. A serious working implication has arisen in this case, given Mental Health Officer 14's perspective towards medical colleagues.

This reluctance to make contact is echoed in the findings of a research study concerning working relations among mental health social workers, Community Psychiatric Nurses (CPNs) and General Practitioners (GPs) (Sheppard, 1992). He found that social workers were clearly more reluctant than CPNs to contact GPs, and also GPs were more reluctant than CPNs to contact social workers.

Male informant 9 has often disagreed with medical staff:

I have been criticised in hospitals by doctors who feel that I am taking too much time to make up my mind and it has happened before...what I am saying is we are often called out in the middle of the night when there are junior doctors in the Royal Edinburgh, for instance, and the junior

doctors...all they have [are] written instructions 'if such and such a patient is risking or demanding or trying to leave - if it's written in the notes - he or she is detainable therefore request a Mental Health Officer' and often they are just acting under instruction and they are quite inexperienced themselves and the situations I often we often overturn it even if they say it's detainable, I often don't agree with them...

As part of an emergency social work team, this Mental Health Officer is often called on to carry out mental health assessments on an emergency basis. He often disagrees with the medical view of whether someone ought to be detained in hospital or not. This different view by the MHO appears to be a confident approach to take, although this informant does point out that in such situations he is often working with junior doctors who may be relatively inexperienced. Yet, this Mental Health Officer feels the need to be more confident, as he states:

...more confidence would come with more training and I would feel maybe a bit more at ease with some of these other professionals.

The professionals which informant 9 is talking of include the police and doctors. The suggestion is that he is not completely at ease with the role of Mental Health Officer and he would like more training which he believes would give him more confidence. This appears to be contradictory to the view he outlined earlier of often disagreeing with the medical viewpoint and, in relation to sections, overturning them sometimes. The discrepancy arises between the description of practice and self-reflection on the role and how he carries it out. This discrepancy indicates a lack of confidence on the part of this Mental Health Officer in considering how he functions within the role, a lack of confidence which is not reflected in the decision-making abilities that he relates. The lack of confidence may be connected to the criticism he has experienced from doctors concerning how long he takes to make decisions.

In interview with Mental Health Officer 9, I state:

...because I refused consent and the doctor involved complained to my area officer and I just thought you know it is part of my role and I am entitled to actually refuse consent, I gave him what I thought were pretty good reasons why but it was like as you say the rubber stamp hadn't been I hadn't produced the magic rubber stamp so I had to be then questioned...

This situation was one where I as Mental Health Officer did not agree with a doctor that a section 24, of the Mental Health (Scotland) Act 1984, needed to go on to a section 26, of the Mental Health (Scotland) Act 1984. This experience left me feeling frustrated that it seemed I was not accepted on a professional basis by the doctor concerned and my judgement needed questioning. It was a realisation of how junior I thought the male doctor saw my role. The decision I made was upheld by social work management. From personal experience, then, there are difficulties in maintaining a professional and open working relationship in such circumstances. The personal, in terms of emotion, can threaten the professional and this emotional threat may influence decision-making in practice.

Female informant 6 also made a different decision to a doctor, and in this case as a student Mental Health Officer. She states:

But I disagreed with this doctor that was on and the doctor wasn't at all pleased and I gave my reasons why I didn't want this woman to be detained at this particular time, and the doctor didn't accept it, brought in the consultant, however we stuck to our decision and that was that but part of that placement as well I actually had to go and work on that ward, and that doctor carried that on throughout my placement on that ward, never spoke to me.....I just couldn't get over that...it was almost as if you know she hadn't got her way and she was in the huff with me because I hadn't agreed with her decision, so I think yes you have to kind of be as sure as you can of what you are saying and stick with it...

This was a confident decision for a student Mental Health Officer to make, that is to decide differently to the consultant, although she was supported in this by her placement supervisor. The professional and personal overlap is indicated in the emotional reaction which the informant states the doctor displayed by being in the 'huff', and not communicating. Personality seems to intrude negatively into the

professional role and this intrusion affects the working relationship, an effect which in turn can affect work with service users or patients. Lack of communication between professionals can have potentially serious consequences in that decisions affecting service users can be taken which are not as informed as they could be. In this example, for instance, the doctor is in danger of not fully hearing the Mental Health Officer's assessments including the social circumstances of patients.

Another point that this informant's statement makes indicates that the Mental Health Officer is to make a decision and 'stick with it'. This phrase suggests a lack of flexibility and unwillingness to alter assessment through the influence of another perspective, such as the medical view. This informant's view is in alignment with other Mental Health Officers' views of being 'up against' the medical profession, an approach that could easily result in an unshifting perspective on the part of social work staff. Again, in terms of practice, this perspective would not appear to be very beneficial to service users or patients, since an aim of multi-disciplinary working is to include all professional perspectives in order to reach fully informed decisions. If, however, a professional group does not consider itself to be heard in such circumstances, then a danger is that the group will become intransigent in its views. Multi-disciplinary training sessions may help to alleviate this problem by each professional group learning to appreciate the role and contribution of others, and perhaps looking to new ways of working together.

Male informant 16 also considers that professional groups should learn more of each others' roles. He states:

I also think we should work closer with health colleagues...letting them know what our role is...you get it from consultants, you get it from say the set of outreach teams - the role of a Mental Health Officer is housing and benefits and that is what we are meant to do, that is what we are meant to be knowledgeable about...so all this training for housing and benefits

The motivation for this MHO to suggest consultation between the social work and medical professions seems to stem from frustration because he believes that the

medical staff regard the social work staff as limited in knowledge to housing issues and welfare benefits. This frustration has been part of his experience and he would like to see the situation altered.

Male informant 20, on the other hand, had previously trained and worked as a psychiatric nurse and he shows considerable understanding of the medical perspective and differences between the mental health social work and medical perspectives. He states:

I think that [the social work course] was certainly a really big influence, and an influence to change my view and perspective on mental health, psychiatry, and looking at it from the social side as opposed to from purely a medical point of view.

This informant draws on medical knowledge and mental health social work knowledge in his role as Mental Health Officer. This combined knowledge gives him a positive perspective in valuing the contribution of both of these disciplines but does not seem to confuse him in terms of knowing his role. In this instance, then, broader knowledge has led to wider understanding and appreciation of different professional perspectives.

There are, then, various issues including gender issues raised by informants within the area of multi-disciplinary working, particularly between mental health social work staff and medical staff. These issues tend to be problematic and to focus on difficulties between the professional groups. These difficulties may adversely affect the professional decision-making and the mental health service which users receive.

## **CHAPTER 8**

### **PRACTICE ISSUES AND POLICY IMPLICATIONS**

This chapter explores practice issues and policy implications arising from the gendered aspects of mental health social work. Three current working practices are reported: first, substitution of a mental health social worker for one of the opposite sex; second, joint working; and third, avoidance. Also, six topics affecting mental health social work practice are presented as follows: children; heterosexuality; commonality; patriarchy; age; emotion. Some informants' views throughout the chapter imply organisational responsibility and policy decision-making, for example, deciding in the first instance how certain practices affect the service and, in the second instance, whether any changes are necessary.

The contribution of my study to the legislative and policy background of mental health social work, and also the contribution of my study to the feminist social work literature, are presented.

Finally a section on 'directions for future research' closes the chapter.

#### **Working Practice: Substitution**

Two practice situations sometimes result in substitution being implemented. First, when there is a perceived aggressive threat from male service users, and second, when female service users have experienced abuse from others, particularly men. In the first case, female workers are substituted by male workers and in the second case, male workers are substituted by female workers.



The perceived threat of aggression amongst male service users is one of the main issues which has a direct influence on the practice of some of the Mental Health Officers. As a result, a decision to substitute one worker for another, on the basis of gender, is sometimes taken by informants.

A different decision is made by female informant 4 in a situation where a male service user is abusive towards women, including female workers. She does not consider the option of not working with him. Informant 4's view is that such abuse needs to be confronted by her as the Mental Health Officer. Therefore, in this case there is no change in working practice, such as, substitution of the female worker by a male worker. Male Mental Health Officer 13 also rejects substitution but he offers an alternative by suggesting joint working instead. He argues that substitution may lead to a form of discrimination against female workers through their having to leave some working situations. This practice of substitution suggests circumstances where female workers are not seen as the appropriate choice of personnel on the basis of gender. Substitution, then, is sometimes rejected as a working practice although for different reasons.

Another related issue concerning male service user aggression is raised by male Mental Health Officer 5, who states that he has distinguished between female and male service users when making an assessment regarding detention. He associates an aggressive risk with male service users and he believes that he consequently has detained more male service users than female service users. There is, according to this informant, a probable gender-differentiated frequency of detention rate in the practice of this Mental Health Officer, that is, a detention rate biased towards male service users.

In contrast to the perceived threat of aggressive behaviour from male service users, there is very little consideration given by the informants to the possibility of aggressive behaviour from female service users. Safety issues arising from aggression or potential aggression from female service users are consequently given



very little consideration in terms of working practices by the informants. Kramarae and Treichler (1992) point out that aggression is usually linked with men.

Situations of aggression towards workers are always concerning, particularly when a lapse in the organisation's responsibility to protect workers becomes apparent. This point is implied by female informant 2 who states that she is not sure of how issues of violence or risk concerning service users are made known to workers. The implication is that such procedures are not in place in the organisation or that this worker has not been made aware of them.

The working practice of substitution, then, is sometimes prompted by the perceived aggression of male service users. The practice is also prompted in other situations where female service users have a history of abuse. The working practice, either stated or implied by some informants, both female and male, is where female rather than male Mental Health Officers work with female service users who have experienced abuse.

None of the informants raised as an issue male service users who have experienced abuse. Based on this absence of comment, the issue does not appear to be a routine consideration in the working practices of these Mental Health Officers. Abuse is constructed in female terms by the informants yet men experience abuse of different kinds, for instance, relating to a homosexual orientation.

Organisational and policy implications arise from the practice of substitution. A practical issue is that of numbers and availability of workers, both female and male. This issue has further implications for Mental Health Officer duty rotas and caseloads, and even implications for the numbers of female and male social workers who should be trained as Mental Health Officers. For instance, if a whole area of mental health social work is deemed as requiring male workers, such as when dealing with aggressive male service users, then numbers of male workers need to be trained and available to cover the workload.

Substitution practices have many implications. For instance, should male workers who are uncomfortable with female service users who have experienced abuse be allowed to opt out of this work? Or should the organisation arrange gender awareness training incorporating specific work with service users who have experienced abuse? Should female workers be allowed to opt out of work with aggressive male service users? Or should the organisation put different systems in place to make such work possible and within safety measures?

If workers are allowed to opt out of certain types of work, a difficulty arises in terms of deciding the boundaries of these situations. For instance, would a worker need to justify her/his expressed wish to the organisation? It seems more effective and more likely to produce an efficient service, on the whole, if organisations provide the training and support necessary to encourage and sustain workers in these types of situations rather than to allow them to opt out.

Another issue which stems from substitution as a working practice concerns service user choice and organisational responsibilities. Male informant 17 gives an example of working with a female service user who has experienced sexual abuse. She stated that she would prefer a female worker. However, no female Mental Health Officer was willing to work with this service user, according to this informant. This is a further practice and organisational implication, since the needs or wishes of the service user are raised against departmental resources. In this case, it is not necessarily that the wishes of the service user cannot be practically met, but that there is an unwillingness on the part of workers to do so. There may be many reasons for the viewpoint of the workers. The organisation needs to assess what is required in this situation, and how or whether the requirements can be met.

The conflict of service user rights and those of workers is highlighted in a practice example given by female Mental Health Officer 6. She is one of several workers dealing with a female service user. The latter requests that a female worker be

substituted for a male worker. However, informant 6 is not completely in agreement with the service user's request and questions whether it should be granted. Is a worker entitled to take this view? What of the service user's rights? Clark and Asquith (1985) suggest a list of service user rights, such as: to self-determination; to a professionally competent service; to access to resources for which there exists an entitlement. They state that service user rights to a certain type of service are notoriously difficult to pin down satisfactorily and that practical limitations are particularly significant in instances of this sort. This difficulty is seen in the examples of service users requesting a type of service, specifically a female worker, where there is as mentioned earlier the practical issue of worker availability.

Should practice guidelines take account of the service user's expressed wishes as a principal guiding factor or as one of several needing to be balanced out? There is a potential difficulty that the service user view may be discriminatory regarding choice of worker. In other words, there may be discriminatory reasons why a service user asks to work with a Mental Health Officer of a specific sex. For instance, in a practice example given by male informant 15, he replaces a female worker because the female service user states that she does not wish to work with a female worker. This request arises, according to informant 15, because the female service user does not believe that women should be in positions of authority. This substitution suggests that in accommodating the view of the service user, the Mental Health Officer is supporting a discriminatory perspective. The views of the service user, and particularly the views of the worker, need to be examined for aspects of discrimination in such situations, and the responsibility to ensure this occurs is an organisational one.

In practice situations where a request for substitution of a Mental Health Officer on the basis of gender is made by a service user, a worker or some other body, policy could clarify what to take into account and at what level. Such a clarified decision-making process could benefit both the workers and the service users in laying out what is acceptable in practice and what is not. Rather than allowing for such a

specified policy of substitution practices, an organisation may hold to a policy of no substitution on the grounds of gender. A no-substitution policy does not lack clarity though it may be criticised for lack of choice.

These issues concerning the Mental Health Officer role and gender, such as organisational responsibilities, raise further questions. For instance, are systematic assessments required regarding needs based on gender issues, and should resources be made available to meet these? Should there be flexibility to meet such identified need? On the other hand, should an organisational policy of no substitution be put into place rather than individual assessments and localised targetting of situations when they arise? The uniform approach could argue that it is an active rather than reactive strategy which aims for all workers to work with gender issues and helps to fulfil both service user and organisational requirements. However, the more specific approach tends to rely on individuals, localised resources and working conditions and may be the most effective in delivering care to the service users in local situations.

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### **Working Practice: Joint Working**

There are alternatives to the practice of substitution. Some informants suggest the strategy of joint working with other social workers or with workers from other agencies, such as the police or medical staff, in situations where there is considered to be a safety risk. In the views of these informants, safety issues arise from work with male service users but only exceptionally from work with female service users. There is a difference of emphasis in these views in that safety issues concerning male service users are taken much more seriously than safety issues concerning female service users. Joint working, then, arises primarily when the Mental Health Officers work with men.

Female informants 6, 10 and 14 and male informants 1, 5, 9 and 17 state that they have conducted joint interviews for reasons of personal safety. There are practice and organisational implications from joint working, such as personnel decisions, financial issues for different agencies, and negotiation of the boundaries of responsibility between workers from different agencies to ensure that unnecessary overlapping does not occur.

Christie (1996) states that there is a discourse of 'gender balance' in social work, and that 'gender balance' is related to the numbers of women and men social workers employed. The point of 'gender balance' is that there should be no real imbalance in the numbers of female and male workers within a team. According to Christie, the discourse of 'gender balance' is underpinned by the discourse of heterosexism and helps to justify men's presence in social work. He further states that the need for balance is often associated with the allocation of men workers to men service users and with the co-working of women and men social workers. In my study, co-working tends to be suggested where there is concern about the safety of the social worker. This co-working is often carried out in gender-balanced terms, that is, a female and male worker.

### **Working Practice: Avoidance**

A third working practice of avoidance is reported by some informants. Similarly to joint working, avoidance as a working practice arises primarily when the Mental Health Officer is faced with an aggressive or potentially aggressive male service user.

The experience of female informant 11 reveals practice and policy implications in the situation where she simply chooses not to meet with a male service user that she considers to be aggressive and potentially dangerous towards her. A practice

implication is that the piece of work is not carried out with the service user and constitutes a service withdrawn. Her response is in keeping with the status of a private individual rather than as a member of an organisation to which she has obligations and which has a duty to pay attention to her safety. Whilst this refusal to work with the service user is the choice of the individual worker, such a choice is also implicitly tied up with the role of the organisation. She does not utilise departmental safety systems if there are any, or if there are none, she does not choose to ask the social work department to put a system of safety into place so that she may meet this service user. In the case where no safety system exists the onus seems to be placed on the worker to request, or not request, such safety measures. A policy implication is that the agency needs to assess the safety requirements of its workers and to make necessary arrangements to meet these. The agency also needs to ensure that all workers are aware of and use the safety procedures appropriately.

Mental Health Officers' use of avoidance directly affects the service provided to service users. Some Mental Health Officers state that they have cut interviews with male service users short, or that they have considered doing so, where they perceive there to be a risk to their personal safety. Female informants 7 and 8 and male informants 5 and 17 fall into this category. An organisational question arises of how effective the service is that is being provided to these service users.

Clearly then, these working practices within the Mental Health Officer role have principally arisen from the perception of male service users as aggressive. This perception is the main focus of informants' views which has resulted in gendered working practices. This perception of male service user aggression has potentially wide-reaching implications since it may affect how a mental health social work service is carried out – or even whether it is carried out.

### **Six Topics Affecting Practice**

There are various other topics raised by informants which lead to suggestions of working practices. These topics are – children, heterosexuality, commonality, patriarchy, age, and emotion.

### Children

The typification of ‘female’ and ‘children’ points towards working practices based on gender distinctions in mental health social work. Some of the informants quite regularly take into account the mothering role of women. Sometimes, they differentiate between female and male service users who have children, for example, female service users who have children are sometimes less likely to be detained than male service users who have children.

Taking child-parent relations into account as part of the Mental Health Officer role could be regarded as discriminatory in and of itself because of the categorisation of women with children. In this case, organisational policy would need to reflect this perspective as a discriminatory practice.

If the perspective were to be considered discriminatory, however, this could make grounded mental health assessments very difficult to carry out, since relationships are taken as integral to mental health status, according to most informants. The relevant point, I suggest, is that how assessments incorporate the child-parent, particularly the child-mother, relation needs to be considered carefully in practice, since it is an area that discrimination might enter.

### Heterosexuality

Some informants assume a heterosexual perspective within the worker-service user relation of mental health social work. For instance, male workers may be uncomfortable while working with female service users when there are perceived to be sexual overtones to the interaction. Working practices sometimes develop based



on assumptions of heterosexuality, such as, it is acceptable for a female worker and female service user to have some physical contact but not for a male worker and female service user. This perspective does not take into account the homosexual viewpoint, and nor does it recognise that some service users and workers are homosexual. Therefore, there are implications for both practice and policy if homosexuality is not taken account of in mental health social work.

### Commonality

Based on the concept of shared experiences, or commonality, same-gender working relations are promoted by some informants. These informants consider that it is best at times for female workers to work with female service users and for male workers to work with male service users. Commonality, then, is making a difference in terms of what these informants consider best practice in some circumstances and based on gender issues.

### Patriarchy

The views of some male Mental Health Officers are influenced by patriarchy, such as the assumption of greater male power. Such patriarchal views may influence the working relation, particularly ways of working with women service users. It is questionable that women service users are receiving an appropriate standard of service from these male workers if the women are perceived by the male workers as subordinate because of their gender. Such patriarchal perspectives have consequent policy implications concerning standards of service and gender issues. For instance, it is the organisation's responsibility to ensure that every service user receives an appropriate standard of service irrespective of whether the service user is female or male.

### Age

Age is a consideration to some of the male Mental Health Officers within mental health social work relations. Sometimes the view is taken that commonality leads to more comfortable working practice, for example, common interests between workers and service users, such as music and sport, leading to easier interaction. This male concern with age suggests that such commonality may be sought after in terms of Mental Health Officers' and service users' working relations. There is a related policy issue concerning whether such common ground in working relations should be encouraged as an organisational strategy. For instance, the question arises of whether the service user-worker relation should be based on personal interests as well as the professional role. There are wider issues implied, such as, training, qualifications, and standards of service.

### Emotion

Emotional involvement appears to be regarded positively but also negatively in mental health social work. Some informants have found personal knowledge of emotional issues to be helpful in their professional role by giving them a depth of understanding. Another view is that lack of emotional involvement is a necessary strength of professional workers. These conflicting views suggest different types of practice in the service user and worker relation whereby shared knowledge of emotion is avoided or encouraged. A policy and training issue arises as to whether emotional involvement ought to be regarded as a strength or a weakness in the working relation.

The working practices, then, of substitution, joint working, and avoidance combine with the issues of children, heterosexuality, commonality, patriarchy, age, and emotion to lead to policy and organisational implications for mental health social work services.

### Contributions of this Study

This concluding section focusses on, firstly, the contribution my study makes to the relevant legislative and policy background, and secondly, the contribution my study makes to the feminist social work literature particularly postmodern feminist approaches to social work research.

The legislative and policy background to mental health social work tends not to be explicit concerning issues of gender. A major policy initiative has been that of community care. This was made explicit with the National Health Service and Community Care Act 1990. Orme (2001) states that in the formal policy statements of community care, gender has not been overtly referenced although it impacts at all levels in service provision.

Orme (2001) further argues that understandings of both community and caring by policy makers have ignored the complexities of gender analysis by, for instance, equating the category of 'gender' with that of 'women'.

Misra and Akins (1998) state that feminist scholarship suggests welfare policies reflect social inequalities. Perhaps Orme's (2001) suggestion of gender being overlooked within community care policy is one example of social inequality permeating policy statements and initiatives.

The health policies of the Labour Government between 1997 and 2001 increasingly emphasised the contribution Social Work Departments can make to the promotion of health and well-being. A new policy focus was initiated, for instance, to tackle health inequalities by combating social inequalities on both a national level and locality basis (Bywaters and McLeod, 2001).

Social inequalities have been taken into account by the Scottish Executive in making the draft Mental Health Bill which is currently undergoing Parliamentary

process. The Millan Committee recommended that the Bill should have a clear set of underlying principles. This set is broadly consistent with principles in other established legislation, such as, the Adults with Incapacity (Scotland) Act 2000. These principles state that gender has to be taken into consideration in various ways, for example, the principle of equality and the principle of respect for diversity. The Scottish Executive document 'Renewing Mental Health Law' includes the principle of respect for diversity as follows:

Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background (2001, Executive Summary p.1).

There have been developments, then, concerning gender issues in mental health legislation and policy in Scotland over the period in which I carried out my study and particularly latterly. Various outcomes from these developments remain to be seen, such as, how the principles of the draft Mental Health Bill will be enacted in practice and how gender considerations will be realised. These issues are of particular relevance given the findings of my study concerning gendered assumptions and practices within mental health social work. For instance, is the practice of avoidance consistent with the Bill's underlying principles? Future research could examine the gender issues raised.

Another area to which my study contributes is that of feminist, and particularly postmodernist feminist, social work literature. Feminism has criticised social work literature for ignoring gender. Orme (2001) states that generic social work texts do include gender issues, or more accurately acknowledge feminist theory, but that the analysis is at times simplistic and rarely addresses the complexity of social relations which constitute understandings of gender. She further argues that the social work discourse positions women at its centre but this has not been theorised in terms of emergent feminist arguments in the literature. My study, then, is fairly unusual in

the social work literature, and specifically mental health social work literature, because it is focussed on meanings of gender.

Trinder (2000) states that much social work research largely excludes consideration of gender issues, and that which does concern itself with gender issues is mainly of the standpoint feminist approach. This approach tends to privilege the standpoint of women but not the standpoint of men as they are seen as the dominant group (Harding, 1993). My own study, in contrast, has focussed on the complexities of the social relations of gender, for instance, differences within the social groups 'women' and 'men' as well as differences between the groups. I adopted a postmodernist black feminist approach based on current feminist theoretical debates and arguments.

Orme (2001) considers that despite the problematics posed by postmodernism, with its denial of a unified subject, its contribution has been to revisit definitions of gender. She argues that those definitions which include the social relationships between women and men have influenced feminist social workers to widen theoretical analysis and practice to include work with men. Feminist qualitative research studies have tended to involve women as informants, although studies involving men as informants have been undertaken more recently. This is the case in my study where the inquiry has involved both women and men, as female and male Mental Health Officers.

A criticism sometimes levelled at postmodernist thought is that it focusses on language and text at the expense of analysing the construction of social inequalities, such as, that between women and men (Busfield, 1996). In my own study, postmodernist analysis has been conjoined with black feminist thought, particularly in Collins' (1991) model which emphasises the experiences of women and men. Some black feminist scholars, such as Collins, have been influenced by postmodernism in their theorising. This postmodernist black feminist approach has been a stimulating one for my project by, for instance, highlighting difference from



a *both/and*, rather than an *either/or*, perspective towards penalty and privilege along various axes of domination. This has focussed on multiplicity and complexity and has led to findings concerning, for instance, gender and age, gender and sexual orientation, and also the relation of gendered assumptions to gendered working practices in mental health social work.

Postmodernist feminist social work research is a recent phenomenon and my study forms part of it. Research such as this raises interesting questions not limited to standpoint feminism's emphasis on women. Rather, men as well as women are considered as gendered subjects, and gender is seen as interlocking with various axes, such as, race, disability and sexual orientation.

As Trinder states:

Other research approaches still have much to offer, but the development of a postmodern feminist informed theory and research practice is important in its own right as well as potentially generating a productive dialogue with other non-postmodern feminist approaches (2000, p.39-40).

### **Directions for Future Research**

Directions for future research are suggested in several areas in my study, such as, heterosexuality in the views of Mental Health Officers, gendered working practices, and gender issues in working relations between Mental Health Officers and medical staff.

There is a strong emphasis on heterosexuality in some Mental Health Officers' views, for instance, concerning the sexual behaviour of service users. Future research could examine the implications of these views for assessment and service provision, particularly in relation to homosexual service users.

Gendered working practices by some Mental Health Officers have been found in my study, such as substitution, joint working, and avoidance. Future research could study any of these practices for what they mean in terms of service provision and organisational responsibility towards service users. For instance, the practice of avoidance constitutes a withdrawal of service. What should the organisation do in such situations?

Gender issues in the working relations between medical staff, particularly doctors, and Mental Health Officers could be examined in future research projects. These working relations are often constituted in terms of difficulty by informants in my study. Future research could examine what gender-based difficulties between these professional groups mean for multi-disciplinary working and service provision.



## **APPENDICES**

### **APPENDIX 1**

#### **INTERVIEW SCHEDULE** **PILOTS**

##### **Introduction**

(thanks; outline of project; any questions?)

##### **Biographical Details**

Details to find out:

- Marital status?
- Any children?
- Age?
- Post held?

##### **Working as a MHO**

- How long have you worked as a MHO? In different places? What were they like to work in?
- Do you work in other areas of social work as well, such as, child care?
- Did you receive training to become a MHO? (What? When?)
- What would you say interested you in mental health work? Was there any particular reason, or event, which influenced you into working in the area of mental health?

##### **Gender Issues (1)**

- Do you think that a person's mental health is influenced by their relationships with other people?
- (If so, do you think that there will be any difference between how a man's mental health problems are influenced by his relationships and how a woman's mental health problems are influenced by her relationships?)
- Can you tell me, do you think the principal symbolic figure of madness in western culture is that of the madman, the madwoman, neither or both? (eg. In films, in art, in literature)
- Do you consider the mental health problems of women to be similar to those of men or different from those of men?
- Can you tell me, do you think that gender and ethnic background interact with the mental health of an individual?

##### **Life Experience**

(see Appendix 3 – experience of researcher told to interviewees)

- Have your own views of mental health, and mental health problems, been altered as a result of any experiences you have had?
- (If so, has this had an influence on the way you think, and are, as a MHO?)

- Have your views of mental health changed at all since you began working as a MHO? (What? Where? When? How? Why?)

### Service Users

I would like to ask you some questions now about the mental health problems of service users.

- Can you tell me what you take in to account when you assess the mental health of service users?
- What would you say that you take in to account when you are assessing the views of relatives of service users?
- Would you say that any gender discrimination occurs in MHO-service user relations?
- Would you say that any racial discrimination occurs in MHO-service user relations?

### MHO Role

- Can you say to me what your thoughts and feelings are towards 'sectioning' as part of the MHO role?
- Is there anything you would take in to account which is different depending on whether it is a man or a woman you are considering 'sectioning' for? (Perhaps in order to answer that you might want to talk about a case, or cases, you have dealt with)
- Do you enjoy working as a MHO? (What? Why?)
- What do you like least in the role? (Why?)
- Do you think the fact that you are a fe/male MHO is advantageous in any way to understanding mental health difficulties, or do you think it may be disadvantageous?

### Ethnic Background and Gender (vignette)

Please read this vignette, which is based on an Asian woman, Shahnaz, who lives with her husband and children in a British city. (interviewee is handed vignette)

"Shahnaz's problems went back to the time her father in law remarried. She had the feeling that her new relatives did not really accept her, that they thought she was unworthy. Shahnaz felt desperately lonely, and longed for support.

'I get frightened, and it feels as though there's a ball rolling round in my stomach. I'm terrified that something bad is going to happen. I think constantly in my heart.'

Shahnaz's anxieties about what her new in-laws might do to discredit her were compounded by her fear of being attacked or robbed.

'I'm afraid that something bad is going to happen, so I don't go out on my own at all... If I have to go to the clinic, I wait for my husband. He works in a restaurant and this means that he is home most mornings. But he's away from the house from half-past-two in the afternoon till two or three in the morning. I'm in a state of terror all that time. I lock all the doors and the windows when he leaves – there are a lot of people around here prepared to do that, you know – English and Black people. We're always afraid of them. We rarely take the children to the park. We just go in to the garden when the weather is fine.'

- Do you think that discrimination from others against her ethnic background is involved in keeping Shahnaz from leaving her house whenever she wants to?
- (If so, how much is it involved?)
- Do you think that discrimination from others against her gender is involved in keeping Shahnaz from leaving her house whenever she wants to?
- (If so how much is it involved?)
- Could you comment on the level of Shahnaz's anxieties concerning her new in-laws?

### Gender Issues (2)

- What do you think of the following statement: 'The mental health problems of men should be considered from the perspective of gender discrimination as much as the mental health problems of women.' (Why would you say you think that?)
- Do you think that there are any areas of mental health understanding which do not require considerations of gender, or might even be hampered by considerations of gender? (Why?)

### Colleagues and Support

I have a few questions now about working with other colleagues.

- Do you enjoy on the whole working with other professionals, such as, GPs?
- Do you think you get much support from your own colleagues?
- If you are looking for support, do you tend to turn to female colleagues or male colleagues, or does it not matter? (Why is that?)

Now, a question concerning structure:

- In your experience, is the way social work is structured fair and reasonable, or not? Why?

### Understanding of Mental Health

Can you tell me what you think of the following statement: 'The mental health problems of white people should be looked at from the perspective of racial issues as much as the mental health problems of people of colour.'

- Can you tell me what you understand by the concept of mental health?
- Can you tell me what you understand by the concept of madness?

### Closing

(thanks; any questions or comments on the project?; findings to be made available through the department)

## **APPENDIX 2**

### **INTERVIEW SCHEDULE**

#### **Introduction**

(thanks; outline of project; any questions?)

#### **Biographical Details**

- Title of post held?
- Age?
- Marital status?
- Children? (If yes, do you find it reasonably easy to balance having a family and the job of social worker, particularly MHO?)
- What did you do before you worked in social work?

#### **Working as a MHO**

- What took you in to social work? Was it just by chance, or due to a particular event in your own life, or was it a conscious career move, for instance?
- How long have you worked as a MHO?
- What interested you in working in the area of mental health? Was there any particular reason or event which influenced you in to working in this area?
- Have you worked in various social work locations? (If so, how did you find them to work in?)

#### **MHO Role**

- Based on your experience of mental health work, do you think the fact that you are a female/male MHO has been advantageous in any way to understanding mental health difficulties, or do you think it may have been disadvantageous?
- Can you say to me what your thoughts and feelings are towards 'sectioning' as part of the MHO role?
- Is there anything you would take in to account which is different depending on whether it is a man or a woman you are considering 'sectioning' for?
- Have you ever felt threatened or in a situation of risk as a MHO?
- Has there been a time when being a male/female MHO has helped you in terms of working with a 'mental health case'?
- Has there been a time when you felt being a male/female MHO was a hindrance?

### Gender Issues (1)

- In your experience of working as a MHO, do you find that a person's mental health is influenced by their relationships with other people? (If so, in what ways? Also, if so, do you find that there is any difference between how a man's mental health problems are influenced by his relationships and how a woman's mental health problems are influenced by her relationships?)
- Do you find in your experience that the mental health problems of women are similar to those of men or different from those of men?
- Can you tell me, do you think that gender and ethnic background interact with the state of mental health of an individual?
- What do you think of the following statement: 'The mental health problems of men should be considered from the perspective of gender discrimination as much as the mental health problems of women'? Why?
- From your experience, do you find you have a preference for working with male or female service users or no real preference?
- Do you think that there are any areas of mental health understanding which do not need considerations of gender, or might even be hampered by considering gender?
- You are obviously aware of gender issues, what would you say has made you aware? (optional)

### Life Experience

(see Appendix 3)

- Have your own views of mental health, and mental health problems, been altered as a result of any experiences you have had? (If so, how?)
- Have your views of mental health changed at all since you began working as a MHO?

### Gender Issues (2)

- Is service user gender something you prefer to routinely take account of in MHO work or is it something that you prefer to concentrate on when specific problems and issues arise?
- Would you say from your experience of working as a MHO that gender issues crop up often or not, for example, more than in other types of social work, less or similar?

### Colleagues

- Do you enjoy, on the whole, working with other professionals, such as GPs or psychiatrists?
- Do you think that you get much support from your own colleagues?
- If you are looking for support, do you tend to turn to female or male colleagues, or both?
- What were the qualities of the line manager you have most enjoyed working with?
- What were the qualities of the line manager you have least enjoyed working with?

### Closing

Some of this interview has been concerned with gender and mental health, is that something you consider to be very relevant to MHO work or on the periphery? Why?

(thanks; any comments or question regarding the project?; findings to be made available through the departmental Research Unit)

### **APPENDIX 3**

#### Life Experience Statement by Researcher

I would like now to tell you about an experience in my own life which had an influence on my views towards mental health.

A few years ago, someone close to me was regularly taking tranquilisers, and in fact she was addicted. Her family and friends, including myself, did not know about this. She had been receiving tranquilisers on repeat prescription for years and this only came to light when she had trouble with her back and had to go in to hospital for an operation. The medical staff stopped all her usual medication including the tranquilisers. As a result she suffered from hallucinations and withdrawal symptoms. She was transferred quickly to a psychiatric hospital where she received various treatments including electric shock treatment. Before this she had no history of mental health problems so it was a shock. The experience of it being so close to me and not knowing made me reflect on how this was hidden, nobody had realised or noticed. It also made me wonder, when she attended her GP at first, what she was feeling and what she actually wanted help for; how she saw any problems she had. Also, I have wondered how others around her might have helped, including myself.

This experience has had an influence on me in terms of my attitude towards mental health and it was something that stayed with me when I began to train as a MHO, and may well have had a place in taking me in to that area of work.

### **APPENDIX 4**

#### Diary Extracts

##### Female Interviewee X

‘To begin with X’s answers were relatively short and to the point, however as the interview went on she relaxed more and gave longer, more involved, answers. I found X quite easy to talk to and we shared some ‘laughs’. It was interesting that initially X said she did not really think of mental health in gender terms but as the



interview progressed it became obvious that she had seen and considered gender differentiation.'

#### Male Interviewee Y

'Y was quiet in his manner and fairly intense. However, he had a quirky sense of humour which helped to relax the interview. I enjoyed listening to some of the unusual ways of looking at things that Y had. He appeared to enjoy the interview and to let his mind be creative in what he was saying. This made the discussion stimulating.'

### **APPENDIX 5**

#### Summaries

##### Female Interviewee A

- similarities between wo/men's mental health problems; no differences fe/male re. 'sectioning'; no differences re. relationships
- egalitarianism in view; no areas are hampered by gender but gender issues crop up more in mental health work
- explanation of oppression based on personal experience
- view re. gender issues based on experience and also training
- gender discrimination is an experience of men as well as of women

##### Male Interviewee B

- some gender differences in field of mental health e.g. more women in hospital; more work with women generally in mental health social work
- no differences re. 'sectioning' between wo/men
- male/female system is the status quo
- gender discrimination is an experience of men as well as of women
- being a male MHO is advantageous in the hospital system
- personal experiences and training have informed views of gender
- enjoys using the authority of the MHO role



## **ABBREVIATIONS**

MHO: Mental Health Officer

GP: General Practitioner

CPN: Community Psychiatric Nurse

RM: author of thesis

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